

Sexual Safety of Mental Health Consumers Guidelines

Summary The purpose of these guidelines is to - Support mental health services to meet their responsibilities in relation to the sexual safety of mental health consumers through the provision of practical advice and strategies; - Promote sexual safety to key stakeholders – health staff and managers, consumers and their families and carers; - Clearly outline the information consumers and their families and carers should receive about their rights and obligations in relation to the sexual safety of consumers; and- Improve collaboration and strengthen relationships between mental health services and Sexual Assault Services.

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SEXUAL SAFETY OF MENTAL HEALTH CONSUMERS GUIDELINES

PURPOSE

The Sexual Safety of Mental Health Consumers Guidelines provide practical information, advice and strategies to help mental health services maintain the sexual safety of mental health consumers and respond appropriately to incidents that breach or compromise this safety. Sexual safety refers to the recognition, maintenance and mutual respect of the physical (including sexual), psychological, emotional and spiritual boundaries between people.

These Guidelines should be read in conjunction with Policy Directive PD 2013_038, which mandates the minimum requirements that must be met in this regard.

KEY PRINCIPLES

The key principles in these Guidelines, and the associated Policy Directive, are listed below.

1. All mental health consumers are entitled to be sexually safe.
2. Mental health services take appropriate action to prevent and appropriately respond to sexual safety incidents.
3. Mental health services support mental health consumers to adopt practices and behaviours that contribute to their sexual safety, both within the mental health service environment and within the community.
4. Mental health services develop individual sexual safety standards appropriate for their particular setting, in collaboration with all members of the service including staff, consumers, carers, clinicians, advocates etc.
5. The physical environment of the mental health service takes account of the need to support the sexual safety of mental health consumers in its layout and use, particularly in regard to gender sensitivity.
6. Mental health consumers, and their families, carers and advocates, are given access to clear information regarding the consumer's rights, advocacy services, and appropriate mechanisms for complaints and redress regarding sexual safety issues.
7. Mental health service staff and clinicians foster a compassionate and open culture that encourages reporting of incidents relating to the sexual safety of mental health consumers.
8. Disclosures from mental health consumers about incidents that compromise or breach their sexual safety are taken seriously and addressed promptly and empathetically, regardless of the identity or affiliation of the alleged perpetrator, and with the utmost regard for the complainant's privacy and dignity, past trauma, cultural background, gender, religion, sexual identity, age and the nature of their illness.
9. Mental health service staff are provided with training and education to enable them to:
 - a. Effectively promote strategies to support sexual safety and prevent sexual assault and harassment
 - b. Respond appropriately and sensitively to sexual safety issues involving mental health consumers, both within the service environment and within the community
 - c. Integrate trauma-informed care principles into all aspects of treatment.

10. Mental health consumers are supported to access education to enable them to:
- a. Effectively recognise and respond to behaviours, both their own and other people's, that may compromise or breach their own or another person's sexual safety
 - b. Develop self-protective behaviours
 - c. Establish and maintain good sexual health.

USE OF THE GUIDELINE

These Guidelines apply to NSW Health services providing specialist mental health care in all settings including acute inpatient, non-acute inpatient, rehabilitation and community, and staff working for such services.

Where a service has a mix of acute and non-acute consumers in the one unit or facility, it is the responsibility of the service to ensure they implement these Guidelines and the associated Policy Directive in a way that addresses this mix.

The scope of the Guidelines does not extend to providing practical and detailed guidance about how services can best manage issues relating to sexual activity involving consumers. Services are encouraged to develop their own local policies and protocols in relation to this area, being mindful of the policy approach advocated within these Guidelines regarding the right of consumers to express their sexuality safely and respectfully in the appropriate settings.

The Policy Directive outlines a number of Responsibilities and Minimum Requirements for:

- all Mental Health Services, (pg 11)

with additional Responsibilities and Minimum Requirements specific to:

- acute inpatient mental health settings (pg 13)
- non-acute and residential mental health settings (pg 14)
- community mental health settings (pg 15).

Implementation will be staged over a two year period, and must be completed by June of 2014.

Implementation by individual services should be monitored by each Local Health District via the Individual Service Implementation Monitoring Form at Appendix IV of the associated Policy Directive.

REVISION HISTORY

Version	Approved by	Amendment notes
November 2013 (GL2013_012)	Director General	Inclusion of all mental settings, education, prior history, gender sensitive practices, safe sex practices, respected disclosure, trauma informed care approach and identification of specific incident types.
January 2005 (GL2005_049)	Director General	New policy.

ATTACHMENTS

1. Sexual Safety of Mental Health Consumers: Guidelines

Sexual Safety of Mental Health Consumers Guidelines

Practical information, advice and strategies to help mental health services maintain the sexual safety of mental health consumers



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Contents

1. Introduction	3	3. Fostering a culture that supports sexual safety.....	16
1.1 Definitions.....	3	3.1 Training and education	16
1.2 Principles of care	5	3.1.1 Supporting mental health staff	16
1.3 Scope	5	3.1.2 Empowering consumers	17
1.3.1 Settings.....	5	3.1.3 Recognising families, friends and carers	18
1.3.2 Focus.....	6	3.2 Promoting sexual safety	19
1.3.3 Population groups.....	6	3.3 The importance of collaboration	19
1.4 Purpose and intended outcomes.....	6	3.3.1 Consumers.....	19
1.5 Background.....	7	3.3.2 Families and carers	20
1.6 Development process	7	3.3.3 General practitioners (GPs).....	20
1.6.1 Expert practitioners.....	7	3.3.4 NSW Health Sexual Assault Services ...	20
1.6.2 Literature review.....	7	3.3.5 NSW Police Force.....	21
1.6.3 Consultation.....	7	3.3.6 Other agencies	21
2. Sexual safety and mental health.....	9	3.3.7 Partner programs/Community managed organisations (CMOs).....	22
2.1 Defining sexual safety.....	9	4. Preventing a Sexual Safety Incident ...	24
2.2 The importance of sexual safety for people with a mental illness.....	9	4.1 Sexual assault and harassment.....	24
2.3 Sexual safety incident types	10	4.1.1 Assessing vulnerability	24
2.3.1 Sexual assault and harassment	10	4.1.2 Taking an appropriate sexual assault and harassment history	24
2.3.2 Consensual sexual activity in an inappropriate context or setting	11	4.1.3 Recognising offender tactics.....	26
2.3.3 Sexually disinhibited behaviour.....	12	4.1.4 The role of gender sensitivity.....	26
2.4 Rights and responsibilities regarding sexual safety.....	12	4.1.5 Practical security measures	27
2.4.1 Mental health consumers in all settings have the right to:.....	12	4.1.6 Maintaining professional boundaries .	28
2.4.2 All members of a mental health service have the right to:	13	4.2 Consensual sexual activity in an inappropriate context or setting.....	30
2.4.3 Mental health services in all settings have a responsibility to:	13	4.2.1 Sexual safety standards	30
2.4.4 All members of a mental health service have a responsibility to:.....	13	4.2.2 Addressing sexuality needs	30
2.5 Relevant legislation, standards/rights and policies	13	4.3 Sexually disinhibited behaviour	31
2.5.1 Legislation	13		
2.5.2 Standards and rights.....	14		
2.5.3 Associated NSW Health policies	14		

5. Responding to a Sexual Safety Incident	35	Appendices	57
5.1.1 When there is disclosure or acknowledgement of sexual assault or harassment	35	Appendix A – Example Sexual Safety Standards of Behaviour	58
5.1.2 When sexual assault or harassment is suspected but not disclosed	41	Appendix B – Charter of Victims Rights.....	59
5.2 Consensual sexual activity in an inappropriate context or setting.....	43	Appendix C – Relevant standards and the legislative framework	61
5.2.1 Understanding consent and capacity.....	43	Appendix D – Information about support options for consumers who have experienced sexual assault	64
5.2.2 Staff attitudes	44	Appendix E – Information about reporting to Police for consumers who have experienced sexual assault.....	65
5.3 Sexually disinhibited behaviour	44	Appendix F – Example posters on accessing support.....	66
6. Reporting and Recording	47	Appendix G – Sexual Assault Screening Tool	68
6.1.1 Reporting	47	Appendix H – Examples of sexualised behaviour by healthcare professionals towards consumers or their carers	70
6.1.2 Recording	49	Appendix I – Responding to a disclosure of sexual assault – key actions	71
6.2 Consensual sexual activity in an inappropriate context or setting.....	50	Appendix J – Responding to a disclosure of recent sexual assault – quick checklist	73
6.2.1 Reporting	50	Appendix K – Follow up medical exams required when a person has been sexually assaulted.....	74
6.2.2 Recording.....	50	Appendix L – Reporting process for an incident of sexual assault	75
6.3 Sexually disinhibited behaviour	51	Appendix M – Information about Managing Disinhibited Behaviour.....	76
6.3.1 Reporting	51	References	77
6.3.2 Recording.....	51		
7. Highly vulnerable groups	52		
7.1 Consumers who are Aboriginal and Torres Strait Islander	52		
7.2 Consumers who are children or young people	53		
7.3 Consumers from a culturally and linguistically diverse background.....	54		
7.4 Consumers with Intellectual Disability.....	54		
7.5 Gay, Bisexual, Lesbian and Transgender Consumers	55		
7.6 Older consumers	56		

Introduction

1.1 Definitions

For the purpose of this resource, the following definitions apply.

Term	Meaning
Consensual sexual activity	Sexual activity that occurs after mutual sexual consent has been provided by those involved. Also see 'sexual consent'.
Consumer	Someone with a mental illness or disorder that uses a mental health service.
Continuum of sexual violence	A range or succession of related sexual behaviours involving intrusion and violation, extending from unwanted sexual comments to unwanted touching of a sexual nature and rape.
Gender sensitive practices	The different needs of men and women are considered in all aspects of service planning and service delivery.
Intra-familial sexual assault	Any sexual activity between closely related persons, normally within the immediate family, which is either illegal or socially forbidden. Immediate family can include a parent, son, daughter, sibling (including a half-brother or half-sister), grandparent or grandchild, being such a family member from birth.
Informed decision	A decision made by a consumer who understands the nature, extent, or probable consequences of the decision, and can make a rational evaluation of the risks and benefits of alternatives. The decision cannot be considered informed unless the consumer is mentally competent and the decision made voluntarily.
Masturbation	The stimulation of one's own genital organs, usually to orgasm, by manual contact or means other than sexual intercourse.
Mental health service	Any establishment or any unit of an establishment that has the primary function of providing mental health care.
Mental health workers/staff	Any person working in a permanent, temporary, casual, term appointment or honorary capacity within a NSW Health mental health organisation. This includes volunteers, consumer advocates, contractors, visiting practitioners, students, consultants and researchers performing work within NSW Health facilities.
Mentally competent	The capacity to understand information, make decisions, and act reasonably.
Perpetrator/offender	Someone who has breached the sexual safety of a consumer.
Sexual abuse	See 'sexual assault'.
Sexual activity	Activity of a sexual nature with oneself (masturbation) or another (sexual touching, sexual intercourse, oral sex).
Sexual assault	Sexual assault occurs when: <ul style="list-style-type: none"> ■ a person is forced, coerced or tricked into sexual acts against their will or without their consent, or ■ a child or young person under 16 years of age is exposed to sexual activities, or ■ a young person over 16 and under 18 years of age is exposed to sexual activities by a person with whom they have a relationship of 'special care' e.g. step-parent, guardian, foster parent, health practitioner, employer, teacher, coach, priest, etc.
Sexual coercion	The practice of gaining involuntary permission to gain access to a person for the purposes of sexual gratification. Methods used include psychological inducements and physical force e.g. trickery, bribes, inducements (money, food, drugs, etc), offers of care, love, protection, meeting emotional needs, threats, making captive. Coercion is intrinsic in child sexual assault and to the exploitation of other vulnerable persons.

Term	Meaning
Sexual consent	<p>To give permission for something of a sexual nature to happen, agree to do something of a sexual nature, or accept something of a sexual nature proposed or desired by another. Consent can only be considered valid if:</p> <ul style="list-style-type: none"> ■ the consumer is an adult (16 years of age and over) that is mentally competent to consent, and ■ where the consumer is between 16 and 18 years of age, there is no 'special care' relationship with the person to whom they have consented e.g. step-parent, guardian, foster parent, health practitioner, employer, teacher, coach, priest, etc, and ■ the consent is given voluntarily and without coercion. <p>Consent must be provided each time and not be based on prior behaviour.</p>
Sexually disinhibited behaviour	<p>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.</p>
Sexual harassment	<p>Unwelcome conduct of a sexual nature which makes a person feel offended, humiliated and/or intimidated where that reaction is reasonable in the circumstances. Can involve physical, visual, verbal or non-verbal conduct.</p>
Sexual health	<p>A state of physical, emotional, mental and social well-being related to sexuality, including the absence of disease, dysfunction or infirmity; a positive and respectful approach to sexuality and sexual relationships; the possibility of having pleasurable and safe sexual experiences, free from coercion, discrimination and violence, and; respect for the sexual rights of all persons. (World Health Organisation)</p>
Sexual safety	<p>The recognition, maintenance and mutual respect of the physical, psychological, emotional and spiritual boundaries between people.</p>
Sexual safety incident	<p>The term used to refer to an incident that breaches or compromises the sexual safety of a consumer, and which is recognised as either sexual assault or harassment, consensual sexual activity in an inappropriate setting or sexually disinhibited behaviour.</p>
Sexual violence	<p>See 'sexual assault'.</p>
'Special care' relationship	<p>A relationship that exists between a young person 16–18 years of age and a person in a position of influence or authority over that young person. This group could include:</p> <ul style="list-style-type: none"> ■ step-parents ■ guardians ■ foster parents ■ health practitioners ■ employers ■ teachers ■ sporting coaches ■ priests
Survivor	<p>A person who has been sexually assaulted or has experienced sexual harassment. Also see 'victim'.</p>
Trauma informed care	<p>Mental health treatment that is directed by:</p> <ul style="list-style-type: none"> ■ a thorough understanding of the profound neurological, biological, psychological and social effects of trauma and violence on the individual; and ■ an appreciation for the high prevalence of traumatic experiences in persons who receive mental health services. (Jennings, 2004)
Victim	<p>A person who has been sexually assaulted or has experienced sexual harassment. Also see 'survivor'.</p>

1.2 Principles of care

The following principles have been developed to provide a clear foundation for the establishment and maintenance of the sexual safety of consumers in all mental health service settings.

1. All mental health consumers are entitled to be sexually safe.
2. Mental health services take appropriate action to prevent and appropriately respond to sexual safety incidents.
3. Mental health services support mental health consumers to adopt practices and behaviours that contribute to their sexual safety, both within the mental health service environment and within the community.
4. Mental health services develop individual sexual safety standards appropriate for their particular setting, in collaboration with all members of the service – staff, consumers, carers, clinicians, advocates etc.
5. The physical environment of the mental health service takes account of the need to support the sexual safety of mental health consumers in its layout and use, particularly in regard to gender sensitivity.
6. Mental health consumers, and their families, carers and advocates, are given access to clear information regarding the consumer's rights, advocacy services, and appropriate mechanisms for complaints and redress regarding sexual safety issues.
7. Mental health service staff and clinicians foster a compassionate and open culture that encourages reporting of incidents relating to the sexual safety of mental health consumers.
8. Disclosures from mental health consumers about incidents that compromise or breach their sexual safety are taken seriously and addressed promptly and empathetically, regardless of the identity or affiliation of the alleged perpetrator, and with the utmost regard for the complainant's privacy and dignity, past trauma, cultural background, gender, religion, sexual identity, age and the nature of their illness.
9. Mental health service staff are provided with training and education to enable them to:
 - a. Effectively promote strategies to support sexual safety and prevent sexual assault and harassment; and
 - b. Respond appropriately and sensitively to sexual safety issues involving mental health consumers, both within the service environment and within the community; and
 - c. Integrate trauma-informed care principles into all aspects of treatment.
10. Mental health consumers are supported to access education to enable them to:
 - a. Effectively recognise and respond to behaviours, both their own and other people's, that may compromise or breach their own or another person's sexual safety;
 - b. Develop self-protective behaviours; and
 - c. Establish and maintain good sexual health.

1.3 Scope

1.3.1 Settings

These guidelines apply to NSW Health services providing specialist mental health care in all settings – acute inpatient, non-acute inpatient, rehabilitation and community – and staff working for such services.

The guidelines outline the recommended policy approach to maintaining the sexual safety of consumers and responding appropriately to incidents that breach or compromise this safety. They should be read in conjunction with Policy Directive PD 2013_038, which mandates the minimum requirements that must be met in this regard.

It should be noted that where a service has a mix of acute and non-acute consumers in the one unit or facility, it is the responsibility of the service to ensure they implement these guidelines and the associated Policy Directive in a way that addresses this mix.

1.3.2 Focus

The focus of these guidelines is sexual safety for consumers. Sexual safety refers to the recognition, maintenance and mutual respect of the physical (including sexual), psychological, emotional and spiritual boundaries between people. Advice regarding how to manage incidents of sexual assault or harassment that do not involve consumers of the service can be accessed from a range of NSW Health policies, including *Complaints Management Policy PD2006_073* and *Criminal allegations, charges and convictions against employees PD2006_026*. See Section 2.5.3 Associated NSW Health Policies for further information.

The scope of these guidelines does not extend to providing practical and detailed guidance about how services can best manage issues relating to sexual activity involving consumers. Services are encouraged to develop their own local policies and protocols in relation to this area, being mindful of the policy approach advocated within these guidelines regarding the right of consumers to express their sexuality safely and respectfully in the appropriate settings.

However, NSW Health recognises that good sexual health and healthy and respectful sexual relationships are important and intrinsically linked to sexual safety. For this reason, information about sexual health issues is included where appropriate, and sexuality and sexual health education for consumers and training for staff is acknowledged as an important component of an overall sexual safety strategy.

1.3.3 Population groups

Information specific to the needs of consumers who are particularly vulnerable, including children and young people, is provided in Section 7.

At relevant points throughout the document advice is also provided around the responsibilities of service providers in relation to the safety, welfare and wellbeing of the children and young people who may be in contact with or in the care of consumers using an adult mental health care service.

The reforms to the NSW child protection system under *Keep Them Safe: A Shared Approach to Child Wellbeing 2009–2014* mandates that every health worker that comes into contact with a child or young person has a responsibility to protect their health, safety, welfare and wellbeing.

The NSW Health Frontline Policies and Procedures for Child Protection and Wellbeing (*revised procedures being finalised at the time of printing*) operationalise the responsibilities of NSW Health under the *Children and Young Persons (Care and Protection) Act 1998* and are relevant to all health workers and services, including those providing services to adult clients who may be parents or carers.

1.4 Purpose and intended outcomes

The purpose of these guidelines is to:

- Support mental health services to meet their responsibilities in relation to the sexual safety of mental health consumers through the provision of practical advice and strategies.
- Promote sexual safety to key stakeholders – health staff and managers, consumers and their families and carers.
- Increase the awareness of all stakeholders regarding the importance of:
 - Training for staff to enable them to prevent and respond to sexual safety incidents; and
 - Access to education for consumers to enable them to recognise behaviours that could compromise or breach their sexual safety, develop self-protective behaviours and attain good sexual health.
- Clearly outline the information consumers and their families and carers should receive about their rights and obligations in relation to the sexual safety of consumers.
- Improve collaboration and strengthen relationships between mental health services and Sexual Assault Services.

The intended outcomes of the guidelines are:

- Prioritisation of the sexual safety of mental health consumers by mental health services.
- An increase in the number of mental health staff who are appropriately trained to manage sexual safety issues.
- Reduction of the number of sexual safety incidents in inpatient and rehabilitation units.
- Greater promotion of the responsibilities of mental health services in relation to sexual safety, including their role in supporting consumers within the community.
- Awareness by mental health staff of the benefits of

helping consumers to access education on sexuality and sexual health issues.

- Awareness by consumers and their families and carers of the rights and responsibilities of consumers regarding their sexual safety.
- A greater sense of confidence within the community regarding the sexual safety of mental health consumers.
- Stronger collaboration between Sexual Assault Services and mental health services.
- Consideration of prior sexual trauma of consumers within the treatment context.

1.5 Background

These guidelines supersede the *Guidelines for the Promotion of Sexual Safety in NSW Mental Health Services*, which were first released in 1999 and revised and re-released in 2005.

Since that time, feedback to the Mental Health and Drug and Alcohol Office (MHDAO) and the Clinical Advisory Council (CAC) has indicated that the guidelines in their current format may not have been providing the appropriate level of support to mental health service staff regarding how to respond to sexual safety issues.

Points raised in relation to the guidelines included:

- Insufficient information provided regarding how staff should respond to particular sexual safety issues (e.g. prior sexual assault trauma; consensual sex; identifying offender tactics etc)
- Limited scope – only applicable to inpatient units
- Did not take account of the differing needs of particular groups, such as children and adolescents, older people, Gay, Lesbian, Bisexual and Transgender (GLBT) people, Aboriginal people, culturally and linguistically diverse people etc.
- Out of date information regarding reporting procedures, including the use of mental health clinical documentation (formerly MH-OAT)

In response to this, CAC agreed to review of the guidelines with a view to improving their effectiveness, and this action was endorsed by the Mental Health Program Council (MHPC). This also provided an opportunity to develop a Policy Directive to improve consistency across services and clarity around responsibilities as well as to review and revise the current

format and content of the sexual safety training provided to mental health services.

As the new guidelines are about promoting sexual safety, and preventing and appropriately responding to sexual safety incidents in all settings, the title has been changed to *Sexual Safety of Mental Health Consumers* to reflect this.

1.6 Development process

1.6.1 Expert practitioners

A range of expert practitioners provided input and guidance throughout the development process, including individuals from the following sectors:

- Sexual assault prevention and response education
- Sexual Assault Services
- Community mental health
- Inpatient mental health
- Mental health rehabilitation
- Violence prevention

Consumer representatives from the NSW Consumer Advisory Group – Mental Health (Inc) also contributed to the development of the framework and content of this document.

1.6.2 Literature review

A literature review was undertaken, primarily utilising electronic research methods, regarding sexual safety issues within a mental health service context that encompassed national and international literature.

The review also identified strategies and recommendations for improving sexual safety in mental health services and examples of tools, guidelines and policies that would support better management of sexual safety issues for consumers.

This information, along with additional research undertaken around the importance of sexual ethics and sexual health information for consumers in preventing sexual assault and harassment, provided a framework for development of the guidelines.

1.6.3 Consultation

Consultation was considered a critical component in the development of the guidelines.

A reference group, comprised of key stakeholder groups and individuals, provided regular feedback to the project throughout the development process. Sectors represented included:

- Forensic mental health
- Children and adolescent mental health
- Older people's mental health
- Carers and families
- Multicultural mental health
- Aboriginal mental health
- Mental health consumers
- Patient safety

Further consultation was also undertaken with the following stakeholder groups at fundamental stages:

- ACON
- Aboriginal Health and Medical Research Council
- Adults Surviving Child Abuse
- Ministry of Health Mental Health Clinical Advisory Council
- Ministry of Health Mental Health Program Consumer Sub-committee
- NSW Police Force
- NSW Rape Crisis Centre

Academics that reviewed and endorsed the guidelines include:

- Professor Moira Carmody, University of Western Sydney's Centre for Educational Research, former member of the National Council to Reduce Violence against Women and their Children, national expert on sexual assault prevention education
- Dr Lesley Laing, Senior Lecturer, Undergraduate and Pre-service Programs, Program Co-director, Faculty of Education and Social Work, University of Sydney, former Director of the Education Centre Against Violence (ECAV)

SECTION 2

Sexual Safety and Mental Health

2.1 Defining sexual safety

Sexual safety refers to the respect and maintenance of an individual's physical (including sexual) and psychological boundaries.

Core elements of sexual safety in a mental health service include:

- A safe physical environment
- Recognition of the rights of consumers to physical and psychological safety
- Assessment of the consumer's vulnerability or potential to harm others
- Identification of the consumer's past experience of sexual assault
- Consideration of how the service environment could be improved, including adoption of gender-sensitive practices
- Monitoring of professional boundaries
- Management of sexually disinhibited behaviour and prevention of sexual activity in an inappropriate context or setting
- Provision of professional development for staff
- Appropriately responding to sexual assault and harassment
- Proper reporting and recording of sexual safety incidents, and feeding back outcomes of cause analysis into safety improvement processes at the service level.

2.2 The importance of sexual safety for people with a mental illness

Mental health consumers are exposed to a number of potential risks, particularly when they are acutely unwell. Often these risks are related to their own behaviour or to the behaviour of other consumers, or are a direct result of their mental illness. Others relate to safety risks from their care or treatment. This makes mental health consumers a particularly vulnerable group within the health sector.

Mental health consumers can be more vulnerable to sexual assault in particular for a number of reasons, such as:

- Low self esteem and confidence
- Social isolation and loneliness
- Poor social and communication skills
- Impaired judgement, due to their mental illness, medication(s) prescribed for their illness or drug and alcohol abuse, or a combination of these
- Interruption of usual developmental stages due to onset of mental illness combined with limited education regarding relationships, appropriate sexual behaviour and sexual safety.

In the community, this complex mix can also include an increased likelihood of living in poverty with fewer resources and options to change their living circumstance and lack of access to outside assistance. In an inpatient or residential rehabilitation setting, the power imbalance between staff and consumers, either real or perceived, can lead to a fear of retribution if the disclosure involves a staff member.

According to research, the prevalence of people with a mental illness who have been exposed to or have experienced personal trauma, including sexual abuse and violence, is high. There is also evidence to suggest that:

- The influence of violence can persist long after the abuse has stopped.
- The more serious the abuse, the greater its impact on physical and mental health.
- The impact over time of different types and multiple episodes of abuse appear to be cumulative (Evans 2007; Golding 1999; Taft 2003; WHO 2000).
- Suicidal ideation is more common among victims/survivors of sexual assault than the general population (Stepakoff, 1998) and younger victims/survivors may be at particular risk of actually attempting suicide following rape (Pettrak, 2002).

This highlights the need for greater awareness of the sexual vulnerability of people with a mental illness, and the link between mental health issues and prior sexual assault and violence.

It also confirms the important responsibility mental health services have to ensure that policies and procedures are in place to support consumers to be sexually safe, and that care and treatment plans take account of sexual safety issues and adopt a trauma-informed care approach.

2.3 Sexual safety incident types

For the purposes of these guidelines, the types of behaviour that can breach and/or compromise the sexual safety of a mental health consumer have been split into the following three incident types:

- Sexual assault and harassment
- Consensual sexual activity in an inappropriate context or setting
- Sexually disinhibited behaviour

Within the context of these guidelines, each of these behaviours is referred to as a **'sexual safety incident'**.

2.3.1 Sexual assault and harassment

Definitions

Sexual assault is a broad term used to describe a range of sexual acts committed against a person without their consent. It occurs when:

- a person is forced, coerced or tricked into sexual acts against their will or without their consent, or
- a child or young person under 16 years of age is exposed to sexual activities, or
- a young person between 16 and 18 years of age is exposed to sexual activities by a person with whom they have a relationship of 'special care' e.g.. step-parent, guardian, foster parent, health practitioner, employer, teacher, coach, priest, etc.

Sexual assault is a crime of violence with serious consequences. Conviction for sexual assault is punishable by law and depending on the category of assault, can carry a gaol term. The *Crimes Act 1900* sets out offences of a sexual nature at Part 3, Division 10. See *Appendix C – Relevant standards and the legislative framework* for further information about what this Act says.

Sexual harassment can occur between any combinations of individuals and is defined by the Australian Human Rights Commission as *'unwelcome conduct of a sexual nature which makes a person feel offended, humiliated and/or intimidated where that reaction is reasonable in the circumstances.'*

Sexual harassment can involve conduct such as:

- unwelcome touching, hugging or kissing
- staring or leering
- suggestive or offensive comments or jokes
- unwanted invitations to go out on dates or requests for sex
- intrusive questions about an individual's private life or body
- unnecessary familiarity, such as deliberately brushing up against someone
- insults or taunts of a sexual nature
- sexually explicit emails or SMS messages
- behaviour which would also be an offence under the criminal law, such as physical assault, indecent exposure, sexual assault, stalking or obscene communications.

Sexual harassment is **not** sexual interaction, flirtation, attraction or friendship which is invited, mutual, consensual or reciprocated.

Sexual assault and sexual harassment potentially affect all members of the community. However, there are certain groups that are more likely to be targeted than others, and this includes men and women with a mental impairment (Cook, 2001).

Beyond Belief, Beyond Justice (Goodfellow and Camilleri, 2003) notes that women with cognitive impairment (including women with cognitive impairment from mental illness) are especially vulnerable to abuse, particularly those who are homeless or living in boarding houses or institutional settings.

Impact

Sexual assault and sexual harassment for those who experience it can affect their short and long-term physical and mental health, their economic wellbeing, and their feelings of safety.

Of all the traumatic stressors researched, trauma of sexual assault is the strongest predictor of Post Traumatic Stress

Disorder and is associated with increased rates of other mental disorders including depression, anxiety, anti-social personality disorder, substance dependence, suicidal ideation and suicide attempts.

The immediate emotional consequences of sexual assault might include terror, anguish, disgust, personal vulnerability, shock, numbness and denial. The long-term emotional impact can be experienced in many ways including:

- Disturbed sleep
- Frequent nightmares
- Flashbacks to the assault
- Embarrassment, shame, eroded self-esteem
- Poor body image, weight gain used as a protective mechanism
- Depression and anxiety
- Hostility, anger, and behavioural problems
- Self-harming and compulsive behaviours (including self-mutilation, reckless behaviour, drug and/or alcohol abuse)
- Relationship difficulties and loss of sexual confidence
- Feelings of isolation, guilt or self-blame, suicidal thoughts and suicide attempts

Overall, the reactions to sexual assault of both women and men tend to be similar (Crome, 2006), but research addressing the impact on men has been limited. Some impacts of particular relevance to males include sexual orientation conflict, homophobia, male specific sexual dysfunction and compulsions, and masculine identity confusion.

Sexual harassment is a type of sexual assault, and victims/survivors of severe or chronic sexual harassment can suffer the same psychological effects as victims/survivors of sexual assault.

2.3.2 Consensual sexual activity in an inappropriate context or setting

Definitions

For the purposes of the guidelines, *consensual sexual activity* is any activity of a sexual nature (sexual touching, sexual intercourse, oral sex) that occurs between people over the age of 16 years after mutual sexual consent has been provided by those involved, who have been

assessed as having the capacity to consent.¹ The term *inappropriate context or setting* refers to consensual sexual activity taking place in an environment or associated with a set of circumstances that is not considered to be suitable, such as:

- An acute inpatient setting
- A public area of a non acute, residential or rehabilitation unit
- When a health worker suspects that a consumer has been coerced into engaging in sexual activity or was unwell at the time that the activity occurred.

Impact

The impact for consumers of consensual sexual activity in an inappropriate context or setting will vary based on the individual circumstances involved, but could involve:

- sexual exploitation
- damage to self esteem and other relationships
- sexually transmitted infections or pregnancy

Witnessing sexual activity, even if it is consensual, can also be traumatic for others within the service setting, particularly those that have previously experienced sexual assault or harassment.

When a mental health worker or clinician is involved, the consequences could include:

- significant and enduring harm to the consumer
- damage to the trust that should exist between consumer and mental health worker or clinician
- the mental health worker or clinicians decisions about care and treatment may be influenced to the consumer's detriment
- a breach of the NSW Health Code of Conduct (PD2012_018) resulting in disciplinary action against the mental health worker or clinician
- criminal charges being laid against the mental health worker or clinician.

¹ Note: It is a crime to have sexual intercourse with a young person between the ages of 16 and 18 if you are in a relationship of 'special care' with that young person, regardless of whether they consent to this. 'Special care' relationships include step-parent, guardian, foster parent, health practitioner, employer, teacher, coach, priest, etc.

2.3.3 Sexually disinhibited behaviour

Definitions

Sexual disinhibition is an inability to restrain sexual impulses and involves behaviour or talk which is considered inappropriate for a particular environment. This behaviour arises for a variety of reasons that can include a mental illness or disorder, dementia or Alzheimers, or the side effects of medication.

Behaviours can exist on a continuum and can escalate in severity, from an increase in sexual thoughts through to indiscriminate sexual activity.

Impact

Sexually disinhibited behaviour can be embarrassing, distressing and potentially dangerous for the person exhibiting the behaviour as well as for those that may be exposed to it. It can also negatively impact on existing relationships and for those that have experienced a prior incident of sexual assault or harassment, being exposed to this behaviour can trigger strong feelings of fear and anxiety.

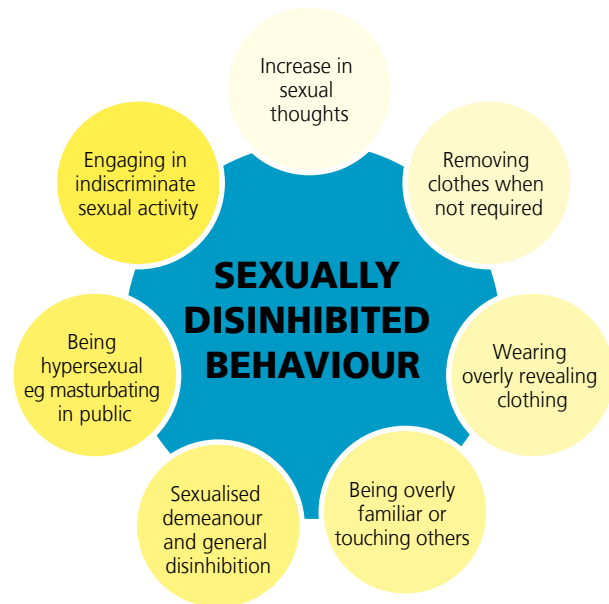
Sexually disinhibited behaviour also has the potential to make consumers exhibiting this behaviour vulnerable to sexual assault or harassment.

2.4 Rights and responsibilities regarding sexual safety

In protecting the sexual safety of consumers, mental health services must ensure that the consumers' rights are respected. Services will also need to understand and promote the responsibilities all members of the service have while in the care of or involved with the service.

2.4.1 Mental health consumers in all settings have the right to:

- **Receive clear information and advice** that takes account of their cultural background, gender, sexual orientation, age and personal experiences regarding:
 - their rights and responsibilities in relation to sexual safety;
 - the standards of appropriate behaviour that exist in the service setting;
 - the process for addressing a sexual safety incident;
 - the support services available should they experience sexual assault or harassment; and
 - how to manage sexual health issues, such as contraception, sexually transmitted diseases (STDs) and pregnancy.



- **Be heard and believed** regarding their experience of sexual assault and harassment.
- **Be treated with compassion and understanding** when they disclose incidents that have compromised their sexual safety.
- **Be supported** by the person of their choice after a sexual safety incident has occurred, whether this is a family member, friend, preferred staff member or other advocate.
- **Receive prompt treatment** once their experience of sexual assault and harassment is disclosed, whether this experience occurred prior to or after their admission to a mental health service.
- **Be informed about their options** after experiencing a sexual assault or sexual harassment, **and have their wishes respected**, particularly regarding whether to:
 - Remain within the service environment in which the assault occurred, or be moved to another environment;
 - Disclose their experience of sexual assault, including to their carer and/or family;
 - Make a formal complaint to the NSW Police Force,² Talk to a Sexual Assault Service; and
 - Undergo a medical or forensic examination.
- **Be protected from further contact** with the alleged perpetrator of a sexual assault or sexual harassment when in the care environment, regardless of whether this is a staff member, a consumer, the consumer's family member, carer or friend or a casual visitor.

² An allegation of sexual assault must be reported to NSW Police Force if it involves an employee of NSW Health – PD2006_026

- **Receive support to access sexuality and sexual health education**, if they wish to be involved in such education, and contribute to determining the topics that such education will cover.

2.4.2 All members of a mental health service have the right to:

- **Feel safe** from acts that compromise or breach their sexual safety while in a mental health service environment.
- **Be consulted about and provide input to** the sexual safety standards developed to govern appropriate behaviour within the service they are involved with.

2.4.3 Mental health services in all settings have a responsibility to:

- **Implement and monitor compliance with these Guidelines** to establish and maintain the sexual safety of the consumers who use their service.
- **Develop sexual safety standards that define appropriate behaviour** for the service setting in consultation with all members of the service, including consumers and their families and carers – see Appendix A for example standards.
- **Provide clear information and advice** to consumers that takes account of their cultural background, gender, sexual orientation, and personal experiences regarding:
 - their rights and responsibilities in relation to sexual safety;
 - the sexual safety standards that exist in the service setting;
 - the process for addressing a sexual safety incident;
 - the support services available should they experience sexual assault or harassment; and
 - how to manage sexual health issues, such as contraception, sexually transmitted diseases (STDs) and pregnancy.
- **Ensure consumers are supported to access condoms** in service settings where sexual activity is recognised as appropriate e.g. non-acute inpatient/ rehabilitation and community.
- **Be non-judgemental, compassionate and understanding** when a consumer discloses their experience of sexual assault or harassment.
- **Organise prompt treatment** for a consumer once their experience of sexual assault and harassment is disclosed, whether this experience occurred prior to or after their admission to a mental health service.

- **Explain the available options** the consumer should consider if they have experienced sexual assault or harassment, **and ensure the consumer's wishes are respected unless legislatively prohibited.**
- **Protect the consumer from further contact with the accused perpetrator**, regardless of whether this is a staff member, another consumer, the consumer's family member, carer or friend or a casual visitor.
- **Support the consumer to be free from pressure** to engage in sexual activity with another person, including the consumer's partner or spouse.
- **Help the consumer to access sexuality and sexual health education that is appropriate to their cultural background, gender, sexual orientation, age and personal experiences**, and ensure that consumers are able to contribute to determining the topics such education should involve.

2.4.4 All members of a mental health service have a responsibility to:

- **Respect the rights of others** to feel safe from acts that compromise or breach their sexual safety, regardless of their cultural background, gender and sexual orientation.
- **Read the information provided to them** about sexual safety within the service environ and ask questions as required to support their understanding.
- **Adhere to the sexual safety standards that define appropriate behaviour** for the service setting.

2.5 Relevant legislation, standards/ rights and policies

2.5.1 Legislation

- Anti Discrimination Act 1977
- Child Protection (Offenders Registration) Amendment Act 2000
- Children and Young Person's (Care and Protection) Act 1998
- Crimes (Sentencing Procedure) Act 1999
- Crimes Act 1900
- Criminal Procedure Act 1986
- Evidence Act 1995
- Health Administration Act 1982
- Health Records and Information Privacy Act 2002
- Victims Rights Act 1996
- Ombudsman Act 1974
- Commission for Children and Young People Act 1998

- Child Protection (Working with Children) Act 2012 – not yet in force.
- Health Services Act 1997

Links to some of these documents online, along with extracts that pertain specifically to these guidelines, are provided at Appendix B and C.

2.5.2 Standards and rights

- Charter of Victims Rights (Extract from the Victims Rights Act 1996 – Part 2, Section 6)
- National Statement of Rights and Responsibilities of Consumers of Mental Health Services
- NSW Ministry of Health Charter for Mental Health Care in NSW
- NSW Police Force, Health and Office of the Director of Public Prosecutions: Guidelines for Responding to Adult Victims of Sexual Assault 2006
- UN Declaration – Rights of Disabled Persons
- UN Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care

2.5.3 Associated NSW Health policies

- Child Protection and Wellbeing – Information Exchange PD2011_057
- Child Protection Issues for Mental Health Services – Risk of Harm Assessment Checklist PD2006_003
- Child Protection Roles and Responsibilities – Interagency PD2006_104
- Child related allegations, charges and convictions against employees PD2006_025
- Complaint Management Guidelines GL2006_023
- Complaint or Concern about a Clinician – Management Guidelines GL2006_002
- Complaint or Concern about a Clinician – Principles for Action PD2006_007
- Complaints Management Policy PD2006_073
- Coroners' Cases and Amendments to Coroners Act 1980 PD2005_352
- Criminal allegations, charges and convictions against employees PD2006_02
- Disciplinary Process in NSW Health – A Framework for Managing the Disciplinary Process in NSW Health PD2005_225
- Domestic Violence – Identifying and Responding PD2006_084
- Employment Screening PD2008_029
- Improper Conduct – Procedures for Recruitment/ Employment of Staff and Other Persons PD2005_109
- Incident Management Policy PD2006_030
- Interpreters – Standard Procedures for Working with Health Care Interpreters PD2006_053
- Keep Them Safe – Making a Child Protection Report IB 2010_005
- Legal Matters of Significance to Government PD2006_009
- Lookback Policy PD2007_075
- NSW Health Code of Conduct PD2012_018
- NSW Health Frontline Policies and Procedures for Child Protection and Wellbeing (update being finalised at time of printing)
- NSW Health Subpoenas PD2010_065 Open Disclosure PD2007_037
- Privacy Manual (Version 2) – NSW Health PD2005_593
- Protecting Children and Young People PD2005_299
- Reportable Incident definition under section 20L of the Health Administration Act PD2005_634
- Reportable Misconduct under the Medical Practice Act – Guidelines for practitioners, August 2008 IB2008_062
- Sexual Assault Services Policy and Procedure Manual (Adult) PD2005_607
- Statutory Guidelines under the Health Records and Information Privacy Act 2002
- Violence Prevention & Management Training Framework for the NSW Public Health System PD2012_008

KEY POINTS – SEXUAL SAFETY AND MENTAL HEALTH

- Sexual safety refers to the respect and maintenance of an individual's physical (including sexual) and psychological boundaries.
- Mental health consumers are exposed to a number of potential risks, especially when they are acutely unwell, and are more vulnerable to sexual assault in particular.
- The prevalence of people with a mental illness who have been exposed to or have experienced personal trauma, including sexual abuse and violence, is high.
- The types of behaviour that can breach and/or compromise the sexual safety of a mental health consumer are:
 - Sexual assault and harassment
 - Consensual sexual activity in an inappropriate context or setting
 - Sexually disinhibited behaviour
- Sexual assault is when:
 - a person is forced, coerced or tricked into sexual acts against their will or without their consent;
 - a child or young person under 16 years of age is exposed to sexual activities, or
 - a young person over the age of 16 but under the age of 18 years of age is exposed to sexual activities by someone with whom they have a 'special care' relationship e.g. step-parent, guardian, foster parent, health practitioner, employer, teacher, coach, priest, etc.
- **Sexual assault is a crime.**
- Sexual harassment is unwelcome conduct of a sexual nature which makes a person feel offended, humiliated and/or intimidated where that reaction is reasonable in the circumstances.
- Consensual sexual activity is any activity of a sexual nature that occurs:
 - between people over the age of 16 years, or over the age of 18 years if there is a 'special care' relationship between those involved; and
 - after mutual sexual consent has been provided by those involved; and
 - when those involved have been assessed as having the capacity to consent .
- Sexually disinhibited behaviour involves actions or talk of a sexual nature that is considered inappropriate for a particular environment.
- In protecting the sexual safety of consumers, mental health services must ensure that the consumer's rights are respected and the responsibilities of all members of the service are promoted and upheld. See Section 2.4 for further information.
- Services will need to familiarise themselves with the range of relevant legislation, standards and NSW Health policies. See Section 2.5 for further information.

Fostering a culture that supports sexual safety

For consumers to feel sexually safe, services will need to foster a culture that encourages and supports consumers to report a sexual safety incident. This will involve strong leadership that inspires transparency and trust.

Transparency means the degree to which information flows freely within the service, among managers and staff, and outward to consumers, their families and carers, and other key stakeholders. Trust means members of the service can communicate upward and honestly, teams can challenge their own assumptions freely, and managers and clinicians can successfully communicate important messages to staff.

Training and education, promotion and collaboration will all play a critical role in supporting services in this regard.

3.1 Training and education

3.1.1 Supporting mental health staff

Service staff

Training is essential for all frontline staff and managers around sexual safety and sexual assault and harassment.

Awareness and knowledge of the impact of sexual assault and harassment, and the implications of sexual offender tactics, informs clinical practice and can significantly improve treatment outcomes for consumers. This in turn can reduce the possibility of consumers being re-traumatised, both while in the care of a mental health service and when they move into the community.

Training also provides staff with the opportunity to reflect on many of the common myths held within society about sexual assault. This reflection in conjunction with evidence-based facts can have a positive impact on attitudes around sexual assault and drive cultural change where required.

KEY ACTIONS/POINTS FOR ALL SETTINGS

- All staff need to be aware of and cognisant with their Local Health District policy and procedures that

outline their responsibilities in relation to preventing potential sexual assault and harassment and responding appropriately if an assault or harassment occurs.

- Staff in all settings should be provided with optimal opportunity to attend training on managing sexual safety and this should be provided within an orientation period where possible.
- Such training must include advice about how to appropriately take a consumer's sexual assault history. Other areas or topics for training include:
 - The increased vulnerability of people with a mental illness to sexual assault and harassment
 - Management of sexuality in different health care settings
 - Recognition of signs of sexual assault in different consumer groups
 - What behaviour constitutes sexual harassment
 - Management of disinhibitive behaviour
 - Processes for reporting a sexual assault to Police and requirements for preserving a potential crime scene
 - An understanding of different religious and cultural mores
 - Management and support of the consumer who has experienced previous sexual assault or harassment
 - The sexual rights of people with a mental illness
 - Child protection issues in relation to children and young people living with or related to a consumer
- Education may also be required around how to discuss sexual safety issues with consumers and their families and carers in a sensitive and non-sexualised way.
- Any training and education should include gender-sensitive and trauma informed care practice principles. Having clinical supervision systems in place will also support staff in developing their understanding of gender sensitive practice, trauma informed care, and professional boundaries.
- Refresher training should be considered for all staff annually.

KEY ACTIONS/POINTS FOR ACUTE INPATIENT

- Training for staff working in an acute inpatient setting must include risk assessment of consumers for victimisation or offending and management of disinhibitive behaviours.
- Support to appropriately utilise tools such as environmental audits will also be required.

KEY ACTIONS/POINTS FOR NON-ACUTE/ RESIDENTIAL AND COMMUNITY

- Promoting safety within settings where a consumer's right to consensual sexual activity is respected can be supported through education on topics such as assessing a consumer's capacity to provide sexual consent and understanding the tactics of coercion.
- Staff in community based and residential services who are involved in case management will also need information and advice regarding how to manage the particular issues that exist when home visiting.

Consumer workers and representatives

Consumers often feel a particular level of trust in confiding in and disclosing to consumer workers. This makes consumer workers vital members of the service environment.

KEY ACTIONS/POINTS FOR ALL SETTINGS

- Consumer workers must be provided with education and training that mirrors the training provided to service staff.
- This will support them to play a pivotal role in providing advocacy in the event of sexual harassment or assault within services and to gain information from a trauma focused perspective.
- Consumer workers and representatives also need to be able to access training in terms of reflective practice around appropriate boundaries and ethical practice within the context of their workplace roles. Clinicians already receive this training as part of their health qualifications.

Volunteers

Anyone who carries out volunteer work within a mental health service does so to enhance services for consumers. Accordingly, they should be provided with adequate support to help them to be aware of and understand sexual safety issues for consumers.

KEY ACTIONS/POINTS FOR ALL SETTINGS

Volunteers will need education and training regarding:

- The rights and responsibilities of the consumers who use the service;
- Their own responsibilities and the NSW Health Code of Conduct that applies to all health positions or roles;
- How to respond if they receive a disclosure of sexual assault, suspect someone has been sexually assaulted or witness a sexual assault; and
- How to respond if they become aware in the course of their duties that a child or young person may be at risk of significant harm.

3.1.2 Empowering consumers

Empowerment in the context of a mental health service is the meaningful participation of people with mental illness in decision making and activities that give them increased power, control, or influence over important areas of their lives. Any process that prepares people to participate more effectively in an activity that increases their power, control, or influence can be considered empowering.

Consumers can participate more effectively in the establishment and maintenance of their sexual safety through the provision of information and opportunities to be involved in education programs.

It is also important that consumers understand the link between sexual safety and sexual health. The World Health Organisation (WHO) defines sexual health as follows.

Sexual health

A state of physical, emotional, mental and social well-being related to sexuality, including the absence of disease, dysfunction or infirmity; a positive and respectful approach to sexuality and sexual relationships; the possibility of having pleasurable and safe sexual experiences, free from coercion, discrimination and violence, and; respect for the sexual rights of all persons.

World Health Organisation

Good sexual health can facilitate the development of respectful, healthy and equitable relationships and improve attitudes toward gender equity, gender roles, and violence, particularly violence against women.

KEY ACTIONS/POINTS FOR ALL SETTINGS

- Information for consumers should include advice about their rights and responsibilities as they pertain to the service they are involved with as well as the sexual safety standards of the service. Staff can provide this information to consumers in a written format on admission and assist them with understanding the implications at daily unit meetings, within case management relationships and within the context of daily care.
- Consumers should also be advised of the complaints process, including how to access the Official Visitors.
- Information and resources need to be made available in community languages as well as English and access to interpreters and Aboriginal liaison staff made available.
- Consumers in all settings should be provided with opportunities to participate in sexuality education programs as part of a wider preventative approach.
- Such sexuality education must include more than just the biological details of reproductive sex and sexual health, but also engagement with the meaning and negotiation of sexual consent (Carmody, 2003, 2005; Carmody and Willis, 2006; Powell, 2007).

KEY ACTIONS/POINTS FOR ACUTE INPATIENT

- While consumers in an inpatient setting are not encouraged or supported to engage in sexual activity, education and training around ethical behaviour and developing respectful relationships can be beneficial. Such education could include information about:
 - Building self-esteem and resilience
 - Developing the social skills to cultivate and maintain relationships
 - Different types of relationships
 - Coping with relationship difficulties or rejection
- Helping consumers to develop respectful relationships, and promoting alternative ways of relating that are non-violent and non-sexual, can provide an important contribution to the establishment and maintenance of a sexually safe environment. This can also help to prepare consumers to enjoy a healthy and safe sex life once they are well enough to leave the inpatient setting.

- Communicating with consumers verbally about how some of their behaviour can impact on consumers who may have experienced past trauma can also be an effective education strategy.

KEY ACTIONS/POINTS FOR NON-ACUTE/ RESIDENTIAL AND COMMUNITY

- In non-acute/residential and community settings, a significant proportion of consumers are sexually active and may participate in high-risk behaviours, placing them at an increased risk of sexually transmitted infections (STIs), including gonorrhoea, chlamydia, syphilis and HIV, as well as unwanted pregnancy.
- Mental health staff in these settings have an important role to play in providing educative information that promotes sexual health as part of routine care.
- Sexuality education and training should also be offered to consumers in a non-acute/residential setting. In a community setting, information about how to access this education can be provided. Such education can help consumers to recognise and identify inappropriate sexual behaviours, their own and others, develop strong self-protective knowledge and skills³ (e.g. how to assert their right to say 'no') as well as develop a positive and respectful approach to their sexuality and to sexual relationships.
- This education and training could include information about:
 - Sex and relationships, including marriage, same sex attraction and parenting
 - The physical mechanics of sex, including reproduction and masturbation
 - Appropriate and inappropriate expressions of sexuality
 - Sexually transmissible infections
 - Safer sex and contraception
 - Sexuality in older age

3.1.3 Recognising families, friends and carers

A consumer's family and/or carer are an integral part of the care team. Accordingly, they will require information to enable them to understand the importance of sexual safety for the consumer they support and how they can help to ensure it is maintained.

3 Beyond Belief, Beyond Justice – Disability Discrimination Legal Service Inc, Victoria – November 2003

KEY ACTIONS/POINTS FOR ALL SETTINGS

- Families and carers should be provided with advice about the consumer's rights within the service setting and pathways for complaint if these rights are not upheld.
- Additionally, they will need information that indicates what will happen if the consumer they support is sexually assaulted or harassed, or sexually assaults or harasses someone else, and the referral services that are available to help with understanding issues around sexual assault. This information could include advice about disinhibited behaviour, where relevant, to ensure the consumer's partner or family is aware of the connection between this type of conduct and the consumer's illness, and to help them to help the consumer manage their behaviour when in a manic phase.
- Families and carers will also require information regarding the consumer's responsibilities while involved with the service and the sexual safety standards that define appropriate behaviour for the consumers involved with the service.

3.2 Promoting sexual safety

Promoting sexual safety is an important component of any strategy to prevent sexual assault and harassment. The most effective way to promote sexual safety is through the adoption of an ethos that promotes, encourages and models mutual respect in its relationships between staff, between staff and consumers, and between consumers.

Information regarding sexual assault, and about support services for people who have been assaulted in particular, should also be readily accessible. The World Health Organisation recommends that health services consider:

- Compiling a list of local services and telephone numbers that can be kept in a place that is easily accessible.
- Displaying posters about sexual assault and where to go for help on the walls of the facility (having information prominently displayed may make people who have been assaulted feel more comfortable in disclosing and talking about the sexual violence in their lives). See Appendix D, E and F for examples of information and posters that could be utilised for this purpose.
- Placing pamphlets and brochures regarding sexual assault in designated areas, such as toilets and

gender-specific areas, so that consumers can take them away with them or read the information in private.

Other practical promotion strategies include:

- Developing sexual safety standards of appropriate behaviour in consultation with consumers and their carers and families.
- Regularly communicating and promoting these standards to all members of the service, including casual visitors, such as tradespeople or couriers, via posters or written materials.
- Conducting periodic surveys or forums involving consumers, carers and families on the quality of the service, including matters relating to sexual safety.
- Prominently displaying the service's position on sexual safety in the adult acute inpatient unit.
- Discussing behavioural expectations and sexual safety in consumer unit meetings and programs.
- Providing gender specific programs, groups and activities.
- Changing practices to consider sexual safety issues, and communicating these changes to all staff.
- Conducting a clinical review of every sexual safety incident as a matter of urgency.
- Reporting every sexual safety incident through the mental health service incident reporting system. (See *Reporting and Recording* for further information.)

3.3 The importance of collaboration

Maintaining a sexually safe environment within the service, supporting consumers receiving treatment within the community to maintain their own sexual safety, and responding appropriately when a sexual safety incident occurs, will require collaboration with a range of key stakeholders.

3.3.1 Consumers

Consumers have a critical role to play in contributing to the sexual safety of the service environment, and to their own sexual safety, and the safety of others, if they are receiving treatment within the community. Accordingly, they need to be actively involved in developing sexual safety standards of appropriate behaviour for the service they are involved with.

Working collaboratively with consumers in relation to managing sexual safety can also help to empower them, which is an important component of the recovery process in relation to their mental illness.

3.3.2 Families and carers

A consumer's family and/or carer are an integral part of the care team. They can offer critical emotional support to a consumer who has experienced sexual harassment, assault or violence, as well as support to liaise with health care and other professionals, such as Sexual Assault Services and Police. They can also help the consumer to understand and adhere to the sexual safety standards of the service.

However, staff must ensure that the consumer's carer, family or friends are only advised of any sexual safety incident with the express consent of the consumer.

Additionally, staff should be mindful of the high prevalence of intra-familial sexual assault for consumers. Family members may have been or may continue to be perpetrators of abuse, and this must be considered when organising family visits or conferencing.

Staff should also familiarise themselves with the NSW Health *Frontline Procedures for the Protection and Wellbeing of Children and Young People* (revised procedures being finalised at the time of printing) and assess the safety risk to children and young people under 18 who may be living with or have access to an adult consumer exhibiting behaviours that may place a child or young person at risk of harm.

3.3.3 General practitioners (GPs)

GPs are uniquely placed to provide information and support to consumers, as well as their family and carers, in relation to sexual safety and sexual health matters and can provide long-term continuity of care that will support consumers to build a trusting relationship with them.

For those consumers being treated within the community or in a residential setting, the role of the GP in relation to sexual safety can include:

- Providing information about treatment options regarding sexual assault or harassment
- Referring the consumer to local support services, such as a counsellor or the local Sexual Assault Service or rape crisis centre
- Discussing contraception, STIs and other sexual health issues
- Organising a forensic examination if an assault has occurred recently, or conducting this exam if they

have been trained in this field and have the necessary equipment

- Providing follow-up care

All consumers being treated outside of a hospital setting should have a regular GP.

Developing shared care arrangements with a consumer's GP, or linking consumers with a GP in the area, should be a priority for mental health services and all services should have a strategy in place, at either a local or Local Health District level, to strengthen relationships with local GPs.

3.3.4 NSW Health Sexual Assault Services

NSW Health Sexual Assault Services are based in hospitals or community health centres across NSW. They are staffed by specially trained counsellors and are accessible 24 hours a day. Their role is to provide specialist guidance to health staff in responding to incidents as well as counselling and relevant medical assessment and treatment for people who have experienced sexual assault and their family/significant others. This includes:

- crisis and ongoing counselling
- specialist medical and forensic services
- court preparation and support
- community education and prevention
- professional training and consultation
- advocacy

Differing perspectives, along with language differences across service models and frameworks, can be barriers to developing good collaborative relationships between mental health and Sexual Assault Services. However, collaboration between these services offers invaluable support for staff, as well as better outcomes for the consumer who has experienced the assault, through:

- access to other knowledge and information
- consultancy on issues of sexual assault and mental health
- supportive debriefing where appropriate
- breaking down staff isolation
- introduction of new ideas and strategies from people who are outside the sector
- support and advocacy for services in addressing the needs of consumers

Mental health services should look to develop a close partnership with their local Sexual Assault Service, with consideration given to inviting key members of the Sexual Assault Service to visit the service on a regular basis so that consumers are familiar with them. The Sexual Assault Service may also be able to provide recurrent education sessions with consumers around relevant topics, or visit to talk about what they do and how they can help consumers when required. See the **NSW Health Sexual Assault Webpage** (<http://www.health.nsw.gov.au/publichealth/sexualassault/index.asp>) for further information.

3.3.5 NSW Police Force

The role of the NSW Police Force is to:

- ensure that the Charter of Victims’ Rights is observed at all times
- provide protection to victims/survivors of sexual assault who are at immediate or continuing risk, using relevant powers
- investigate reports of sexual assault
- assess the case and decide if there is adequate evidence to proceed with an investigation or to charge an assailant
- apprehend and charge an alleged perpetrator with sexual assault.

Every Local Area Command in NSW has a designated Mental Health Contact Officer (MHCO) at Inspector Rank. One of the responsibilities of the MHCO is interagency liaison with local NSW Mental Health Services. Mental health services can obtain their local MHCOs contact details via their Emergency Mental Health Local Protocol Committee member or by making a request through their Local Area Command. The MHCO can be engaged for any interagency issue or for facilitating training for staff involving Police.

Many NSW Police Officers have also received Mental Health Intervention Team (MHIT) training and some Police Officers have specific training in taking sexual assault statements in a sensitive and respectful way from people who have been assaulted. Mental health services can ask at their Local Area Command for the support of a MHIT trained Officer, and can request a female Police Officer, if one is available.

Mental health services should ensure that they establish and maintain a good working relationship with the local Police service, which should include the development of local protocols to manage reporting of sexual assault or harassment.

3.3.6 Other agencies

There are a range of other agencies that can support both staff and consumers when there is an allegation of sexual assault or harassment. These include what is in the table below.

Services should familiarise themselves with these agencies and the type of support they offer so that they are able to provide relevant options to consumers as required should they experience a sexual safety incident. A handout for consumers may be useful that provides the contact information for these and other local agencies and support groups.

Adults Surviving Child Abuse (ASCA)	www.asca.org.au
Child and Adolescent Sexual Assault Counsellors Inc	www.casac.org.au
The Gender Centre	www.gendercentre.org.au
Intellectual Disability Rights Service	www.idrs.org.au
NSW Department of Community Services	www.community.nsw.gov.au
NSW Rape Crisis Centre	www.nswrapecrisis.com.au
NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS):	www.startts.org.au
Transcultural Mental Health Centre	www.dhi.health.nsw.gov.au/tmhc
Women’s Legal Services NSW	www.womenslegalnsw.asn.au

3.3.7 **Partner programs/Community managed organisations (CMOs)**

Mental health CMOs provide a range of interventions for mental health consumers, including:

- Promotion and prevention to early intervention
- Family and peer support
- Mentoring and counselling
- Community awareness activities and
- Education and training.

In many cases, a CMO can be a consumer's primary non-clinical service provider. This makes CMOs important stakeholders whose capacity to support and encourage consumers to consider their sexual safety and sexual health should not be undervalued. CMOs can also provide advice to mental health services in terms of appropriate approaches to effectively engage consumers.

Working collaboratively with CMOs at local level can help to ensure a complementary approach is taken to raising awareness about sexual safety issues for consumers, which avoids duplications, provides continuity of care and more efficient use of limited resources.

KEY POINTS – FOSTERING A CULTURE THAT SUPPORTS SEXUAL SAFETY

Training and education

- Training and education, promotion and collaboration will all play a critical role in supporting services to foster a culture that encourages and supports consumers to report a sexual safety incident.
- Training is essential for all frontline staff and managers around managing sexual safety, inclusive of taking a consumer's sexual assault history. Such training must include gender sensitive and trauma informed care principles. Consumer workers and volunteers will also need training. See Section 3.1 for further information.
- Education should also be offered to mental health consumers on topics relevant to the setting in which they are receiving care e.g. building the social skills to develop and maintain relationships for consumers in an acute setting; sexuality and sexual health education, including cultivating and maintaining ethical relationships, for consumers in a non-acute/residential setting.
- For consumers in a community setting, help to access such education should be offered if relevant.

Promotion

- The most effective way to promote sexual safety is through the adoption of an ethos that promotes, encourages and models mutual respect in its relationships between staff and consumers, between staff, and between consumers.
- Information regarding sexual assault, and about support services for people who have been assaulted in particular, should be readily accessible. See Section 3.2 for further information.

Collaboration

- Maintaining a sexually safe environment within the service, supporting consumers receiving treatment within the community to maintain their own sexual safety, and responding appropriately when a sexual safety incident occurs, will require collaboration with a range of key stakeholders, including:
 - Consumers
 - Families and carers
 - GPs
 - NSW Health Sexual Assault Services
 - NSW Police Force
 - Other agencies
 - Partner programs/community managed or non-government organisations
- See Section 3.3 for further information.

Preventing a Sexual Safety Incident

4.1 Sexual assault and harassment

4.1.1 Assessing vulnerability

All consumers are vulnerable by the nature of their illness and/or the experience of being hospitalised. Being female in particular increases the consumer's vulnerability to being sexually assaulted or harassed, as is being under the age of 18 years. Other factors that increase the risk for a consumer of being sexually assaulted include:

- Having a past history of being sexually assaulted
- Being a young female experiencing their first admission
- Being heavily medicated
- Being intoxicated and/or having a comorbid drug and alcohol condition
- Having an intellectual disability
- Being Aboriginal or Torres Strait Islander
- Being a refugee/torture and trauma survivor
- Experiencing a psychosis
- Being a victim/survivor of domestic violence
- Sexual disinhibition
- Having a cognitive impairment e.g. delirium
- Impaired communication skills e.g. English competence, hearing speech or visual impairment

KEY ACTIONS/POINTS FOR ALL SETTINGS

- Assessing the vulnerability of a consumer to being sexually assaulted and harassed can support staff to better manage any risk to their sexual safety and should be undertaken on the consumer's admission.
- Any existing screening process (e.g. for domestic violence and/or elder abuse) should be broadened to take account of any history the consumer may have of experiencing or perpetrating sexual assault and harassment (see below).
- If a consumer is assessed as being vulnerable to sexual assault, this assessment must be:
 - Documented within the admission clinical documentation, progress notes and management/care plans, along with what steps will be taken to address this vulnerability; and
 - Communicated to all staff.

4.1.2 Taking an appropriate sexual assault and harassment history

Knowledge about a consumer's previous history of being subjected to sexual assault or harassment can inform staff of the consumer's particular needs and what may or may not be problematic or 'triggering' situations for them. Feeling safe within services is essential for healing and for decreasing vulnerability to further victimisation.

Research indicates that people who have experienced sexual abuse that occurs within an institutional environment are unlikely to disclose the abuse unless they are asked directly.

This reluctance is due to a range of factors, including:

- denial
- fear of stigmatisation
- inability to trust
- loyalty to the perpetrator
- feelings of shame
- inability to identify the experience as abuse or realise that they have a right to safety
- fear of retaliation by the perpetrator or others
- fear of being labelled as a liar, attention-seeking or out of touch with reality

Accordingly, taking a consumer's sexual assault history when they are admitted to a mental health service is critical to enable staff to adequately support the consumer, both in terms of their illness and their sexual safety while involved with the service.

It is important, however, to ensure that this process is carried out when the consumer is comfortable to do so. For acute admissions, taking such a history should be delayed until the consumer is stable.

Taking a consumer's history of *perpetrating* sexual assault is also vitally important to assess the risk that they may continue to offend while involved with the mental health service, separate them from consumers that have been identified as vulnerable and to ensure they receive

appropriate support to recognise their behaviour as inappropriate.

Risk factors for offending include:

- Having a history of sexually offending behaviour
- Having a history of domestic violence offending
- Violent and threatening behaviours
- Intimidating behaviours including sexual harassment
- Sexually disinhibitive behaviours
- Acute drug intoxication e.g. methamphetamines

KEY ACTIONS/POINTS FOR ALL SETTINGS

- The process for admitting a consumer to any mental health service should include taking a sexual assault history. A screening tool to help with this process is available at Appendix G.
- **It is critical that only staff who have undertaken training on how to appropriately take such a history, and respond to disclosures, are nominated to conduct the associated assessment.** Alternatively, services may wish to contact their local Sexual Assault Service or another sexual assault counselling service for support or advice for the clinician undertaking this assessment.
- Taking a sexual assault history can be traumatic for the consumer, so those undertaking the assessment must be sensitive to the consumer's feelings and needs and ensure:
 - The assessment is undertaken only when the consumer is in a stable condition – in acute admissions, a delay may be required prior to undertaking the assessment;
 - Adequate time is set aside for the assessment – the consumer should be allowed to proceed at their own pace; and
 - An appropriately private space is allocated to support the assessment to be undertaken – privacy and confidentiality are key concerns.
- Taking a sexual assault history may also be traumatic for a staff member that has experienced sexual assault or violence themselves. Staff should be cognisant of their own feelings about sexual assault and seek management support to ensure they do not experience re-traumatisation themselves as a result of their involvement in the sexual assault history assessment.
- When possible, family members, carers or friends should not be present during the assessment so that influences and distractions are kept to a minimum. However, the wishes of the consumer must be

respected in this regard – if the consumer feels more comfortable having a support person attend the assessment with them, this should not be discouraged.

- Mental health staff should commence by explaining to the consumer what will happen with the information to be collected, how it will be stored and who will have access to it, which must include the consumer's rights under State and Commonwealth privacy legislation (see Appendix C for further information).
- An explanation should be provided to the consumer regarding why what may be perceived as personal questions are being asked:

'So that I can work out the right way to support you while you are with our service, I need to know a bit more detail about your life before you came here, including any experiences you may have had that made you uncomfortable.'
- The consumer should also be advised that they have the right not to answer at the present time but that the staff member would be available at a future time should the consumer wish to speak with them.
- If the consumer identifies a history of sexual assault/abuse, their experience should be validated:

'Thank you for telling me about such a difficult experience.'

'I'm sure that was hard for you to talk about, but it's good that you did.'
- The consumer's response should be documented in their file using the consumer's own words.
- An evaluation should immediately be carried out regarding the present-day level of danger – refer to **Section 5 Responding to a sexual safety incident** for further advice on actions to take when a sexual assault has been disclosed.
- If there is no immediate danger, the consumer should be:
 - asked if they have previously disclosed the assault or abuse and received any support or treatment:

'Have you had the opportunity to talk to anyone about this before?'

'Have you had any support or help to deal with your feelings about what happened?'
 - offered appropriate follow-up and counselling:

'Sexual assault is devastating in many ways. Let's talk about some things we could do to support you.'
- If support is initially refused, staff should ask the consumer if they are comfortable to talk again about their disclosure and support options and set a time for this.

- Consideration should also be given to how re-traumatisation could be prevented. If the past assault occurred in the current or another mental health facility, every effort must be made to not place the consumer back in the same environment and/or to discuss what might be helpful for the consumer in decreasing the risk of re-traumatisation.
- Where there is no disclosed history of previous sexual assault, clinical practice can still operate from the premise that this history is a possibility. The consumer should also be advised that support is available in the future if they wish to re-visit this topic at a later date: *'That's fine – the reason we ask is that we like to offer people the opportunity to get some support if they want it.'*
- The admission process will also need to take account of any history the consumer may have of violent offending, as this can alert staff to potential problems and inform care plans to maximise monitoring of those deemed at risk for violence.
- Disclosure of alleged sexual assault by a person who may be working with or who has access to children or young people requires a report to the Child Protection Helpline.

4.1.3 Recognising offender tactics

Sexual assault can involve a one-off opportunistic event or a series of ongoing aggressive attacks, but they can be planned attempts designed by those who perpetrate sexual assault to coerce another person to provide sexual favours.

In this situation, deliberate tactics are used to select and abuse vulnerable or desirable individuals. These tactics could include:

- Recruiting these individuals by means of bribes (money, cigarettes, food, other items) or offering perceptions of care, love and intimacy
- Utilising power/positions of power to gain confidence and trust for the purposes of gaining sexual favours
- Maintaining this accessibility by using threats to discourage the individual from disclosing the assault
- Grooming staff by ingratiating themselves as helpful and suggesting to staff that the individual they assaulted is lying

Conditions such as organic brain syndromes may include sexually aggressive behaviours and require appropriate supervision where this occurs.

4.1.4 The role of gender sensitivity⁴

Health policies that are gender neutral assume that men and women are affected equally or in a similar manner by ill health. However, because of social and biological differences, women and men face different health risks, experience different responses from health systems, and their health-seeking behaviour and health outcomes differ (WHO, 2006).

For example, throughout their lifetime, women are more likely to be affected by physical and sexual abuse (WHO, 2006), and have a higher degree of lifetime exposure to sexual abuse and violence (McGee, 2002).

Nonetheless, there should be no bias or any assumptions made by services when a sexual assault is reported or disclosed by a consumer who is a man.

A significant proportion of adults who were sexually abused as children are male, and male consumers who are Gay, Bisexual or Transgender (refer to Section 7.4, p. 63) may have increased vulnerability to sexual victimisation.

Men who are heavily sedated are also more vulnerable to sexual assault. When consumers who are sedated experience a sexual assault, the powerlessness they feel will often be magnified due to their loss of control and choice in such a situation.

The impact of such an experience for a man will not in any way be more significant than for a woman, but may give rise to additional issues because of cultural/social expectations of men. Evidence suggests that services who recognise these gender differences within their care provision, that is those who are 'gender-sensitive', achieve better health outcomes for consumers.

⁴ Information in this section is drawn from the Women's Centre for Health Matters paper entitled 'Gender Sensitive Mental Health Service Delivery', April 2009.

Gender sensitive practices

In the context of a mental health service, gender-sensitive practices include:

- Offering choices about the type of support consumers receive, and who provides it to them (e.g. a choice between a male or female doctor, care coordinator and advocate).
- Providing opportunities for consumers, but women in particular, to be involved in their own care and treatment, including service planning and delivery.
- Having staff that treat both women and men with respect, give them time to talk and listen to what they have to say.
- Having 'women only' spaces within their buildings (see 4.1.5 *Improving the physical environment*).
- Seeing mental health from a holistic perspective, that is, they consider mental health in the context of the consumer's life experiences and personal situations.
- Taking into account the 'social determinants of health', that is, they acknowledge the way that women's and men's personal circumstances and socioeconomic status affects their mental health.
- Recognising a consumer's strengths and empowering them to take control of their own lives.
- Operating in a way that is culturally sensitive to women from outside the dominant culture.

Gender sensitive seclusion and restraint practices

Where seclusion or restraint is used, there needs to be additional sensitivity. Re-experiencing trauma or abuse may trigger the 'fight, flight or freeze' response, which will produce a catecholamine (adrenal) flood. Every effort should be made to avoid retraumatising or triggering events in individuals with trauma histories. Where this is unavoidable, same gender staff should be allocated and consumers should be adequately clothed.

An audit to assess the current level of gender sensitivity within the service should be undertaken to determine priorities for action to increase safety and gender sensitivity. This audit should be carried out every two years.

4.1.5 Practical security measures

Improving the physical environment

Making improvements to the physical environment of a facility can have a real and positive impact on addressing sexual safety issues for consumers. The suggestions provided here regarding changes to the physical environment are supported by the Australasian Health Facility Guidelines.

However, it is recognised that implementing these changes in some facilities may be difficult. Services should work towards introducing similar changes to their facility's physical environment where the layout of the existing facility allows this, and taking account of these suggestions when planning any new facilities.

The NSW Policy Directive Protecting People/Property: NSW Health Policy/Guidelines for Security Risk Management in Health Facilities (PD 2005_339) provide advice for Health Services on maintaining an effective security program that is based on a structured, ongoing risk management process, consultation, appropriate documentation and record keeping and regular monitoring and evaluation.

Single gender corridors/accommodation and bathrooms

Establishing corridors/accommodation and bathroom facilities that are specifically for each gender can greatly improve the feeling of safety for women. Where the design of the unit features a number of corridors radiating out from the nurse station, particular corridors can be designated as either female or male, dependent upon the needs of the service.

Alternatively, where the unit has a long, circular corridor with limited visibility, a lockable door could be constructed at the halfway point of the horseshoe with one half designed as female and the other male.

Women's lounges

Women's lounges can play an important part in helping women to feel safe and more relaxed as well as providing a space where supportive contact between other female consumers and therapeutic relationships with staff can be promoted.

Existing lounge areas located in women's corridors could be designated as women specific or areas which had previously been used as interview rooms could be used for this purpose. These lounges could be established as a sensory /therapeutic room for women with sensory equipment and a massage chair, or used as a venue for women specific group activities.

Family visiting areas

The establishment of gender specific areas where consumers with children and families can visit can enhance the safety and amenity of inpatient environments for these groups.

Family visiting areas need to be located near the entrance to the ward as it is not desirable for children to go through the main part of the psychiatric unit to visit their parent.

Nurse call buttons

The provision of nurse call buttons enables consumers to call for staff assistance in case of emergency. Nurse call buttons could be located in both bedrooms and bathrooms and promoted to consumers within their orientation so that they are aware of their existence.

Lockable bedroom doors

Being able to lock themselves in their bedrooms can greatly contribute to a consumer's feeling of security at night. Consumers could either ask to have their bedrooms locked from the outside, or a mechanism could be utilised that allows staff to override the locks and gain access if required.

Sensory motion detectors

Sensory motion detectors installed in all bedrooms can be activated at night and alert staff if consumers leave their rooms. These detectors can support staff to monitor consumer movement and to prevent inappropriate access to other consumer's rooms, promoting safety and privacy.

Signage

Clear signage in inpatient units can help to stop inadvertent accessing of male/female areas. When the consumer is acutely unwell their usual cognitive abilities may be impaired, so signage and clear labelling can support consumers to read environmental cues.

Labels should be easily understood, with accepted symbols given preference over written language where possible.

Increased vigilance

Increasing vigilance and observation at particular times when staff are less available is a simple yet effective way to increase the safety and security of the service environment. This could include night time, when handover occurs and during ward rounds, when consumers are more vulnerable. A constant staff presence is required in acute inpatient units, including overnight.

Screening of staff

The screening of staff (including volunteers) who apply for roles within a mental health service must be managed in accordance with NSW Health's policies on recruitment and employment screening.

The introduction of increased screening of staff who apply for roles within a mental health service, similar to the working with children check undertaken for those who work with children, should also be considered as part of an overall sexual assault prevention strategy.

4.1.6 Maintaining professional boundaries

Staff in mental health services, like other public sector employees, must conduct themselves in a way that promotes public confidence and trust in their organisation. They have a duty of care to the consumers utilising the service in which they work as well as to other staff.

For the purposes of this policy, the definition of staff includes the following individuals that perform work within NSW Health facilities:

- Volunteers
- Consumer advocates
- Contractors
- Visiting practitioners or Medical Officers
- Students; and
- Consultants and researchers.

NSW Health Code of Conduct

The NSW Health Code of Conduct (PD2012_018) sets out the conduct expected of health staff and applies to staff working in any permanent, temporary, casual, termed appointment or honorary capacity within any NSW Health facility, which includes mental health service environments.

The Code of Conduct makes it clear that sexual involvement with a consumer is a breach of professional and ethical boundaries:

NSW Health Code of Conduct

Sexual relationships with patients or clients –
Section 1.5

I will not exploit my relationship of trust with patients or clients in any way because I recognise that such behaviour is a breach of professional and ethical boundaries and amounts to serious misconduct.

I will not have a sexual relationship with a patient or client during the professional relationship.

Relevant legislation

Sexual activity between a NSW Health staff member and a consumer may constitute a sexual offence under various sections of the **Crimes Act 1900 (NSW)** even if the consumer has not alleged to have been sexually assaulted and/or appears to have consented to the sexual activity.

Under Section 61 of the Crimes Act, a person is not considered to have consented to sexual intercourse if:

- they do not have the capacity to consent, including because of age or cognitive impairment;
- they have the mistaken belief that the sexual intercourse is for medical or hygienic purposes;
- they are substantially intoxicated by alcohol or any drug;
- there has been an abuse of a position of authority or trust.

Under Section 66F (2) of the Crimes Act, a person who has sexual intercourse with a person who has a cognitive impairment, such as a mental illness, and who was responsible for the care of that person, whether generally or at the time of the sexual intercourse, is guilty of an offence. Further information about this Act is provided at Appendix C.

Under Section 66 of the Crimes Act, any person that has, or tries to have sexual intercourse with an under 16 year old, or engages in the 'grooming' of children (as defined in the Act) is guilty of an offence.

Under Section 73 of the Crimes Act, a person who has sexual intercourse with a child aged between the age of 16 and under 18 when they are in a special care

relationship is guilty of an offence punishable by up to eight years prison.

Under section 25A of the NSW Ombudsman Act, allegations against NSW Health staff of sexual assault or sexual misconduct involving anyone under the age of 18 years are required to be notified by the Chief Executive to the NSW Ombudsman and investigated by the employer. Notifications are also required to the Commission for Children and Young People where there is evidence that the conduct has occurred. Refer to the NSW policy directive (PD2006_025) Child Related Allegations, Charges and Convictions against Employees.

Although the **Anti-Discrimination Act 1977 (NSW)** makes sexual harassment a civil not criminal offence, some types of harassment may also be offences under the criminal law. These include:

- physical molestation or assault
- indecent exposure
- sexual assault
- stalking
- obscene communications such as telephone calls and letters.

The **Medical Practice Act 1992** also places an obligation on all registered medical practitioners in NSW to report certain types of misconduct by other registered medical practitioners to the Medical Council of New South Wales. This includes sexual misconduct in the practice of medicine. Further advice about this Act is provided within Appendix C.

KEY ACTIONS/POINTS FOR ALL SETTINGS

- A breach of professional boundaries can occur if a mental health worker displays sexualised behaviour towards a consumer. This is not limited to criminal acts such sexual assault but could also include behaviour such as conducting clinically unjustified physical examinations.
- Appendix H expands on the types of sexualised behaviour that may constitute a breach of professional boundaries.
- If a mental health worker becomes sexually attracted to a consumer and has concerns that this may affect their professional judgement, they should seek guidance from their manager or discuss the matter with a colleague. The development of a culture within mental health facilities which supports staff to discuss

ethical conduct regularly and to report or raise concerns/observations is important.

- If the mental health worker's manager, or the worker themselves, believes that their professional judgement is impaired, they should:
 - Find alternative care for the consumer
 - Ensure a proper handover of care, where necessary
 - Ensure the consumer does not feel that they are in the wrong as a result of the handover of care to another clinician or worker

KEY ACTIONS/POINTS FOR ACUTE INPATIENT

- In an inpatient setting, consumers are extremely vulnerable.
- Maintenance of professional boundaries in this setting can be supported by strategies such as using a chaperone when conducting any examinations of a physical or intimate nature and organising for female staff, wherever possible, to treat consumers, particularly at night.

KEY ACTIONS/POINTS NON-ACUTE/RESIDENTIAL AND COMMUNITY

- In a situation where a mental health worker is attracted to a consumer they must be careful not to display any sexualised or inappropriate behaviour towards them. Outside of the inpatient setting, sexualised behaviour can include:
 - Revealing intimate details to a consumer during a professional consultation
 - Giving or accepting social invitations where this is sexually motivated
 - Visiting a consumer's home unannounced and without a prior appointment
 - Seeing consumers outside of normal practice
 - Clinically unnecessary communications

4.2 Consensual sexual activity in an inappropriate context or setting

Sexual activity is a natural and healthy part of life, and for mental health consumers, reaching out to someone sexually can be a way to attain reassurance through affection and touch. However, when it occurs in an inappropriate context or setting it can be detrimental to those consumers involved as well as to any consumers that may witness the activity.

4.2.1 Sexual safety standards

Having a set of standards that clearly defines appropriate behaviour for consumers in relation to sexual safety will help such behaviour to be adopted. An example set of standards for an acute inpatient and a non-acute/residential and community setting is provided at Appendix A. However, services should use these examples as a guide only – standards should be developed collaboratively with staff and clinicians, consumers, families and carers, advocates etc so that they are meaningful and representative of the service's own individual ethos.

An annual review of these standards should be undertaken to maintain their relevance, which should involve consultation with and input from all of the above stakeholders.

4.2.2 Addressing sexuality needs

Staff should remember that sexuality is a normal part of life and just because the consumer has a mental illness does not mean they do not have normal sexual needs. A consumer may need others to give them space and privacy to express or meet their sexual needs e.g. privacy to masturbate, watch videos or, in a non-acute inpatient, rehabilitation or community setting, to have a sexual relationship.

Masturbation can be a safe alternative to sexual activity with another person and is appropriate for consumers receiving treatment in any setting. It carries no risk of sexually transmissible infection or unwanted pregnancy and can also be beneficial from a health perspective, as it promotes the release of the brain's opioid-like neurotransmitters (endorphins), which cause feelings of physical and mental wellbeing.

'The greatest and most healing service that can be offered to people with psychiatric disabilities is to treat them with respect and honour them as human beings. This means honouring us in our full humanity, including our sexuality and our desire to love and be loved.'

(Deegan, 2001)

KEY ACTIONS/POINTS FOR ALL SETTINGS

- All mental health services have a responsibility to develop individual sexual safety standards appropriate for their particular setting. These must be developed in consultation with all members of the service e.g. staff and clinicians, consumers, families and carers etc.
- These standards should be explained and also promoted regularly to both consumers and staff so that they become embedded in service practice.
- Staff may benefit from training on how to talk about sexual safety and sexual health issues with consumers (see Section 3.1 *Training and Education* for more information).
- Education on sexuality and managing sexual relationships appropriately should also be offered to consumers so that they understand the positive expression of sexuality and can distinguish it from sexual assault.
- Clear advice must be provided to consumers and their families and carers regarding the need for expressions of sexuality, such as masturbation, to be conducted in a place and at a time that will ensure it remains private. It will also be important to ensure that the sexual safety standards for the service include this stipulation, and that consumers are aware of the need to adhere to these standards at all times.
- If masturbation seems to be taking place excessively, for example if it is interfering with day to day living, or taking place in inappropriate situations, it may indicate other issues which need to be addressed.

KEY ACTIONS/POINTS FOR ACUTE INPATIENT

- Consensual sexual activity is not supported in an acute inpatient setting due to the extreme vulnerability of the consumer/s involved, as well as the vulnerability of the consumers that may witness any such activity. Consumers in this setting are generally very unwell, which makes the consensual, voluntary and mutual nature of any sexual activity difficult to confirm.
- Information about this restriction will need to be included within the information provided to the consumer and explained, along with the rationale for its existence, to the consumer and their partner and family or carer. This should be undertaken with extreme sensitivity so that the restriction is recognised as being beneficial for the consumer's safety and care, which is paramount, rather than misinterpreted as an action that is meant to further disempower them.

KEY ACTIONS/POINTS FOR NON-ACUTE/ RESIDENTIAL AND COMMUNITY

- While consensual sexual activity for consumers who receive treatment in these settings is recognised as a normal and healthy part of life, consumers can still be vulnerable to sexual assault and harassment and/or sexually abusive relationships.
- Consumers in these settings should be offered information and access to education that will support them to understand how to manage sexual relationships safely or to recognise and appropriately respond to unwanted sexual advances (see *Education and Training* for more information).
- Consumers should also be provided with clear advice regarding how to report an incident of sexual assault or sexual harassment, and encouraged through education around resilience and building self-esteem to speak up when they or someone else is being mistreated.
- Additionally, consumers in a non-acute/residential setting must be provided with a copy of the sexual safety standards for the service, which should be explained and discussed as required.

4.3 Sexually disinhibited behaviour

Prevention of sexually disinhibited behaviour, whether it is associated with the consumer's mental illness or with a physical condition or disease, such as dementia, will require correct assessment, vigilance and a high level of support for the consumer so that the risk of them being sexually assaulted or assaulting others, being exploited or exploiting others, and retraumatisation of consumers witnessing the behaviour, is minimised.

While the behaviour is generally best managed through the consistent use of simple behavioural techniques, this approach is less likely to be successful with consumers who have dementia due to the way in which the disease impairs new learning. Sexually disinhibited behaviour occurs at some point in most people with dementia, particularly those that are men, and is more common when the disease is mild rather than severe.

KEY ACTIONS/POINTS FOR ALL SETTINGS

- Consumers will need to be assessed by the senior clinician at the time of admission regarding both their vulnerability to sexual assault and exploitation and their potential to assault or exploit others (see 4.1.1 *Assessing vulnerability* pg 36). This assessment will need to consider the likelihood of the consumer exhibiting sexually disinhibited behaviour, any previous occurrences and whether the behaviour is linked to their mental illness or is a result of a physical condition or disease (e.g. dementia) or substance misuse.
- Other key factors to consider within this assessment include:
 - The form the behaviour takes and the context in which it occurs
 - The frequency of the behaviour
 - Contributing factors or triggers
 - Whether the behaviour is problematic and if so to whom
 - The risks associated with the behaviour
- This assessment will support development of an appropriate, agreed and comprehensive management plan. In developing the management plan, services should take account of:
 - The need for a higher level of supervision and monitoring, and the capacity of the service to provide this
 - How to reinforce appropriate behaviour and clothing
 - Any medication that should be prescribed in the treatment of the sexual disinhibition
 - How to minimise retraumatisation for those who have experienced a previous sexual assault
 - Strategies to distract the consumer should their behaviour be associated with dementia
 - Any changes required to the service setting to provide safety for other consumers and staff and privacy for the consumer who may exhibit the behaviour
 - How and what to communicate to the consumer and their family and carer/s about the behaviour and how it can be managed
- Appendix L – *Information about managing disinhibited behaviour* provides further advice regarding factors to consider in the management plan.

KEY POINTS – PREVENTING A SEXUAL SAFETY INCIDENT

Sexual assault and harassment

Assessing the mental health consumer for vulnerability and prior assault

- The vulnerability of a consumer should be assessed at the time of admission in all settings. This includes taking a sexual assault and harassment history.
- Taking a consumer's sexual assault history on their admission to a mental health service is critical to enable staff to adequately support the consumer, both in terms of their illness and their sexual safety while involved with the service. A screening tool to help with this process is available at Appendix G and further information is provided in section 4.1.2
- **Only those staff who have received appropriate training in taking a sexual assault history should manage this process, or support should be sought from the local Sexual Assault Service.**
- Where there is no disclosed history of previous sexual assault, clinical practice can still operate from the premise that this history is a possibility.
- Taking a consumer's history of perpetrating sexual assault is also vitally important.

Gender sensitivity

- Throughout their lifetime, women are more likely to be affected by physical and sexual abuse (Astbury, 2001), and have a higher degree of lifetime exposure to sexual abuse and violence (McGee et al., 2002).
- However, a significant proportion of adults who were sexually abused as children are male, and male consumers who are Gay, Bisexual or Transgender (refer to Section 7.4) may have increased vulnerability to sexual victimisation.
- Evidence suggests that services who recognise gender differences within their care provision, that is those who are 'gender-sensitive', achieve better health outcomes for consumers.
- An audit to assess the current level of gender sensitivity within the service should be undertaken to determine priorities for action to increase safety and gender sensitivity. This audit should be carried out every two years.
- A key strategy to consider in addressing gender-sensitivity and improving security for consumers is to establish gender specific accommodation. Other practical examples of how the physical environment

could be improved to take account of gender-sensitive practices are provided in section 4.1.4.

Practical security measures

- Practical security measures have an important part to play in improving the sexual safety of mental health consumers in an inpatient or long term residential or rehabilitation setting and can include:
 - Increased vigilance
 - Nurse call buttons
 - Lockable bedroom and bathroom doors
 - Sensory motion detectors
 - Clear signage

Staff conduct

- The NSW Health Code of Conduct (PD2012_018), which sets out the conduct expected of health staff, makes it clear that sexual involvement with a consumer is a breach of professional and ethical boundaries.
- Sexual activity between a NSW Health staff member and a consumer may also constitute a sexual offence under various sections of the Crimes Act 1900 (NSW). See section 4.1.6 and Appendix C for further information.

Consensual sexual activity in an inappropriate context or setting

- All mental health services have a responsibility to develop individual sexual safety standards appropriate for their particular setting. These must be developed in consultation with all members of the service and provided to consumers and their families and carers on admission.
- Consensual sexual activity is not supported in an acute inpatient setting due to the extreme vulnerability of the consumer/s involved, as well as the vulnerability of the consumers that may witness any such activity.
- Consensual sexual activity for consumers who receive treatment outside of the acute setting is recognised as a normal and healthy part of life. However, any such activity must adhere to the sexual safety standards for the service.

Sexually disinhibited behaviour

- An assessment will need to be carried out by the senior clinician at the time of a consumer's admission regarding the likelihood of the consumer exhibiting

sexually disinhibited behaviour and any previous occurrences.

- This assessment will support development of an appropriate, agreed and comprehensive management plan for the consumer, which should consider factors such as additional supervision, behavioural strategies, medication etc. See section 4.3 and Appendix L for further information.

Responding to a Sexual Safety Incident

5.1 Sexual assault and harassment

There are four main ways that sexual assault involving a consumer may come to the attention of another person:

- the consumer tells someone they have been sexually assaulted;
- the sexual assault or exploitative behaviour is observed by a third party;
- the behaviour of the consumer changes significantly; or
- the consumer complains of physical symptoms or they are observed by another person.

5.1.1 When there is disclosure or acknowledgement of sexual assault or harassment

Disclosure means telling another person about an incident of sexual abuse, sexual assault, or sexual harassment, or acknowledging to another person that this has occurred, whether the incident is recent, past or ongoing.

Disclosure or acknowledgement is distinct from making a report or allegation (even if sometimes they are one and the same event). Disclosure is about support-seeking, while reporting to Police and making allegations are formal mechanisms to bring an incident to the attention of law enforcement and other agencies. The following information provides guidance about the key actions to take when a disclosure of sexual assault is made. These actions are summarised in Appendix I and a quick checklist provided at Appendix J.

Acknowledging and affirming the disclosure

KEY ACTIONS/POINTS FOR ALL SETTINGS

- Disclosing an incident of sexual assault or harassment can be traumatic.
- The fear of not being believed, an issue for many who are assaulted, may be heightened for people with a mental health problem or mental illness. The stigma that surrounds mental health problems or mental illness can result in a consumer feeling their experiences are not legitimate.
- When a consumer discloses past, recent or ongoing sexual assault or harassment it is essential that staff believe and validate the consumer's experiences rather than make assumptions about what has happened, or how the consumer feels about the incident
- Staff have a responsibility to initiate and adhere to the formal process outlined within these guidelines to respond to disclosures of sexual assault or harassment until assessment of the consumer's clinical mental state determines otherwise (see advice under Exploring the Disclosure).
- Implicit in the provision of a caring and effective response is the understanding that no-one ever deserves to be sexually assaulted or harassed. A judgmental or indifferent response to a disclosure can negatively impact the recovery process.

Exploring the disclosure

KEY ACTIONS/POINTS FOR ALL SETTINGS

- The consumer who has disclosed the sexual assault should immediately be provided a safe, quiet and private space.
- Staff should let the consumer tell them in their own words and at their own pace about their experience and concerns, and unnecessary or repeated questioning should be avoided as this may cause distress.
- Once they feel able, the consumer should be gently encouraged to provide staff with brief details about:
 - the name of the alleged perpetrator
 - where and when the alleged assault or harassment took place
 - any injuries or other concerns that may require medical attention
- Any questioning that is required should be 'open not closed' questioning to prevent any risk of contamination of evidence if a matter proceeds to court. Examples of open-ended questions are, '*Can you tell me more? What happened next? Did anything else happen? When did this happen?*' and so on. These are clarifying questions.

- Consumers may at times retract a disclosure. This may be due to a failure of staff to believe them, and/or because of undue pressure, with negative outcomes for a consumer who persists with a disclosure.
- In the case of individuals who have a refugee background, mistrust of authorities such as health services due to previous political persecutions or torture may result in a retraction.
- A retraction does not mean that an incident of sexual assault or harassment did not occur and that no assessment should take place.
- Pursuing the issue may be difficult without clear support. However should a consumer retract a disclosure, the incident should still be reported and recorded (see *Reporting and Recording*). Should the disclosure involve a NSW Health staff member, the reasons for the disclosure may need to be considered and an internal investigation still completed with a recorded outcome.
- Disclosures, where the alleged perpetrator is a NSW Health employee, must be notified to the relevant manager and managed in accordance with NSW Health policies for managing child related and criminal allegations against employees.
- Where the disclosure relates to a risk of significant harm to a child or group of children, the Child Protection Helpline must be notified.⁵

KEY ACTIONS/POINTS FOR ACUTE INPATIENT

- An assessment of the consumer's clinical mental state must be carried out by the senior clinician (where not involved in the allegation) within 24 hours.

KEY ACTIONS/POINTS FOR NON-ACUTE/ RESIDENTIAL AND COMMUNITY

- An assessment of the consumer's clinical mental state must be carried out by the senior clinician (where not involved in the allegation) within 48 hours.

Establishing and maintaining safety

KEY ACTIONS/POINTS FOR ALL SETTINGS

When the alleged perpetrator is a consumer

- If the consumer who has disclosed the sexual assault wishes to be moved to another room or unit/facility/ service, this request should be accommodated where possible.
- The consumer who has disclosed the sexual assault and the person who has been named as the perpetrator should be separated. The alleged perpetrator should be moved to another facility, unless the consumer who has disclosed the assault specifically requests otherwise or there are other extenuating circumstances. This helps to address the feelings of self-blame that victims/survivors of sexual assault often experience.
- If staff have reason to believe the alleged perpetrator poses some ongoing risks to the consumer who has disclosed the assault or other consumers, all reasonable steps should be taken to minimise risk, including a comprehensive ongoing risk management strategy to prevent any harm.
- Where the alleged perpetrator is a consumer and the person who has disclosed the assault is a child, for example a visiting family member, a report to the Child Protection Helpline (phone 13 36 27) should be made, in addition to taking steps to minimise further risk to the child, or other consumers or staff in the service. Where the consumer who has disclosed the assault is a young person, a report may be made to the Child Protection Helpline. Reports should be made in accordance with the NSW Health Frontline Policies and Procedures for Child Protection and Wellbeing (*revised procedures being finalised at the time of printing*).

When the alleged perpetrator is a NSW Health employee

- Allegations or disclosures of sexual assault against NSW Health staff members must be reported to a relevant line manager and to the NSW Police Force or to the Child Protection Helpline depending on the current age of the victim.
- Allegations of sexual misconduct or sexual assault against NSW Health staff members involving under 18 year olds must be reported to a relevant line manager and will require a notification to the NSW Ombudsman.

⁵ The NSW Government Mandatory Reporter Guide (including a decision tree for sexual assault) can be found at: <http://dr.sdm.community.nsw.gov.au/mrg/app/summary.page;jsessionid=B13F2B7E7C8AFBC0DE2854A2F1E2F6AC>

- An immediate risk assessment must be conducted to determine whether there is any risk to consumers or employees and whether the staff member subject to the allegation requires relocation, supervision or suspension. Once an initial risk assessment is completed, the service must liaise with NSW Police or Community Services regarding the commencement of an internal investigation.
- Any allegations that involve NSW Health staff members must be managed in accordance with the relevant policies for managing child related or criminal allegations against staff. And for managing the disciplinary process.
- A decision regarding whether an entry is required on the NSW Health Service Check Register must also be considered.
- Where an allegation involves the conduct of a health practitioner or health service provider that is not a criminal offence, and does not involve a consumer under 18 years of age, the NSW Health Policy Directive concerning the management of a complaint or concern about a clinician (Complaint or concern about a clinician – principles for action PD2005_007) should be consulted and appropriate action should be taken to inform registration authorities and other bodies, as relevant.

When the alleged perpetrator is a family member or person in a position of continuing power or authority over the consumer

- Staff should consult with their supervisor or appropriate senior manager to explore how to establish and maintain the safety of the consumer in these particular circumstances. This may include approaching the Guardianship Tribunal about the concerns or seeking advice from the Police about obtaining an Apprehended Violence Order (AVO) for the consumer.

Securing any evidence

KEY ACTIONS/POINTS FOR ALL SETTINGS

- If the sexual assault has occurred within the last seven days, staff should immediately secure any evidence related to the sexual assault pending Police involvement, or until the consumer disclosing the sexual assault has made a definite decision not to involve the Police. At the first opportunity, the senior manager or supervisor should also consult with the local Sexual Assault Service, being mindful to maintain the privacy of the consumer.

- Securing the evidence will involve:
 - **Keeping any clothing** that the consumer who has experienced the sexual assault was wearing at the time of the assault – these should only be handled by the consumer to minimise DNA contamination and kept in a safe place in a paper, not plastic, bag and not washed. Appropriate bags can be obtained from the local Sexual Assault Service.
 - **Securing the location** of the assault if possible to prevent any evidence being disturbed.
 - **Securing any CCTV footage** of the incident area – this footage will be required by investigators.

Offering support and options

It is not uncommon for someone who has experienced a sexual assault to minimise their feelings about an assault or to feel that they do not deserve any assistance. However, reassurance that there are services and professionals able to provide assistance and advocacy is important. Support can help to validate the consumer's experience, and assist them to take appropriate steps to deal with a sexual assault.

A sexual safety incident, particularly an assault, can also be stressful for staff. Support and an opportunity to debrief should be offered to the staff member to whom the disclosure was made, particularly when this is a consumer advocate or worker, and to all staff connected with the incident. The local Sexual Assault Service may be able to help with this.

KEY ACTIONS/POINTS FOR ALL SETTINGS

- Staff should calmly outline the available options so that the consumer who has experienced the sexual assault can make an informed decision about how they want to proceed. It is important that they do not feel pressured to take a particular course of action. Information about available options is provided at Appendix D.
- The consumer who has experienced the sexual assault should be informed that they can choose a support person, such as a consumer worker, family member, friend or a staff member that they know and are comfortable with.
- If the consumer does not wish to inform their carer or family, their wishes must be respected, within the limits of legislation. If the consumer's carer and family are informed, they can be referred independently to

the local Sexual Assault Service to learn how they can best support the consumer.

- An interpreter should be made available for the consumer who has experienced a sexual assault who has communication difficulties, for example a consumer with limited English language proficiency or those who are deaf or have a hearing impairment.
- Staff are not required to report a sexual assault to Police if this is against the wishes of the consumer who has experienced a sexual assault, except where:
 - the alleged perpetrator is identified as a NSW Health staff member, or
 - the consumer is a child under the age of sixteen, or
 - the consumer does not have the capacity to make an informed decision and the senior clinician has a duty of care to act in the consumer's best interests.
- All allegations that involve possible criminal conduct involving a staff member must be reported to the NSW Police Force. Where the NSW Police Force undertakes or is undertaking an investigation, an ongoing liaison should be maintained to ensure that investigations are coordinated and re-interviewing is minimised or prevented.
- If the consumer decides to report the assault, staff should offer to immediately refer the consumer to their local Sexual Assault Service and/or arrange for the consumer to talk to the on-call sexual assault counsellor about their options and what services the Sexual Assault Service can provide – including a medical and/or forensic examination, crisis and ongoing counselling and support, and assistance reporting to the Police.
- If a referral is made to a Sexual Assault Service, staff should inform the on-call counsellor about the consumer's capacity to consent, any guardianship arrangements that are in place, whether an interpreter or other support services are required, and whether the consumer has any injuries or medical issues that require immediate treatment.
- At all times, however, staff should be guided by the wishes of the consumer who has disclosed the sexual assault, where possible. It is important that the consumer retains control over decisions, including the decision to report the crime to the NSW Police Force or to contact the Sexual Assault Service.
- This does not prevent the service from consulting with the NSW Police Force and the Sexual Assault Service as long as the consumer is de-identified.

The consumer who has experienced a sexual assault should be informed that:

- They can have the support of a consumer worker, family member, friend, staff member, care coordinator, advocate or other significant person in any interviews.
- They can have access to the local Sexual Assault Service (SAS) for counselling, help in completing a Police report and legal representation, or to simply assist them to make informed choices and decisions.
- Their right to privacy and confidentiality, within the limits of legislation, will be respected at all times.
- Their informed decisions will be respected at every stage of the process.
- It is their decision whether or not to involve the Police and participate in a Police investigation, except in certain circumstances (e.g. where the alleged perpetrator is an employee of the service – reporting is mandatory in these circumstances).

Adapted from the VIC Chief Psychiatrists Guidelines – Promoting sexual safety, responding to sexual activity and managing allegations of sexual assault in adult acute inpatient units

Organising medical care

It is important that consumers who disclose sexual assault are offered medical assistance to treat any physical or psychological injuries, regardless of whether the assault or harassment was recent or occurred some time ago.

Medical care can involve managing physical injuries (including concerns about pregnancy or sexually transmitted diseases), psychological impacts, and possible forensic examinations (to collect any physical evidence that may be used if criminal charges are laid).

Assessment and treatment of physical injuries

KEY ACTIONS/POINTS FOR ALL SETTINGS

- The consumer who has disclosed a recent sexual assault should be encouraged to seek immediate medical assistance to identify and treat any physical injuries they may have sustained as a result of the assault.
- Provided the consumer has given permission for the service to contact them, the local Sexual Assault Service can organise this. If permission has not been given for Sexual Assault Service involvement, the Sexual Assault Service can still be consulted regarding current clinical practice to ensure the most effective treatment is provided.
- Where appropriate, the risk of infection or pregnancy should be discussed with the consumer, and testing recommended. (It should be noted that morning after pills are most effective taken within 72 hours of the assault.)
- Follow-up medical assessments for the consumer are recommended at two weeks, three months and six months post assault and services should liaise with the local Sexual Assault Service involved, or the consumer's GP if relevant, regarding appointments for these assessments to occur. Further information about the medical assessments required when a person has been sexually assaulted is provided at Appendix K.

KEY ACTIONS/POINTS FOR ACUTE INPATIENT

- If the consumer who has disclosed the sexual assault decides not to involve the local Sexual Assault Service, the service itself will need to consider the medical needs of the consumer and organise a medical assessment, with the consumer's consent.
- Staff must ensure that any assessment of or medical treatment for the consumer in the acute inpatient setting is carried out with the consent of the consumer, where they have the capacity to provide this (see *Assessing Capacity* for further information).

KEY ACTIONS/POINTS FOR NON-ACUTE/ RESIDENTIAL AND COMMUNITY

- In this setting, the consumer who has disclosed the sexual assault should be supported to see their local GP, Sexual Assault Service or other support group if they choose to do so.
- If the consumer is not in urgent need of medical treatment, but is assessed as at risk of significant

harm to themselves (i.e. due to suicide or dangerous self-neglect) they may require involuntary admission to hospital under the Mental Health Act.

- In any such situation, extreme sensitivity must be applied, with careful consideration of the importance of minimising any risk of re-traumatisation.

Counselling for psychological injuries

KEY ACTIONS/POINTS FOR ALL SETTINGS

- A consumer who has disclosed a sexual assault can access specialised counselling through their local Sexual Assault Service or may address their experiences of sexual assault or harassment through counselling with a range of different health providers such as mental health staff, counsellors with the Approved Counselling Scheme (Victims Services, Justice and Attorney-General), and counsellors in private practice.
- Counselling can take a variety of forms, and consumers interested in counselling can choose between options such as individual, group therapies, family therapy and/or opt for formal or more informal support.
- Staff should explore with, and support, the consumer to access the types of counselling and social support, if any, that the consumer thinks will be useful and beneficial to help them to deal with their experience of sexual assault or harassment.
- Social support in a group setting is often valuable for people who have experienced sexual assault or harassment especially when they have little or no existing social support as usually:
 - it helps to decrease the isolation that someone who has experienced a sexual assault often feels;
 - it provides a supportive atmosphere;
 - attendees are encouraged to share their experiences;
 - it helps those who have experienced a sexual assault to establish their own support network.
- Staff may wish to establish a sexual assault support group in their facility and/or contact their local Sexual Assault Service to collaborate in establishing and co-facilitating a group for consumers who have experienced sexual assault.
- Mental health services should be familiar with the full range of formal and informal resources that are available locally for victims/survivors of sexual assault and harassment. It is the role of the mental health worker to help consumers identify and choose the most suitable option(s) for their particular requirements.

Organising a forensic examination

KEY ACTIONS/POINTS FOR ALL SETTINGS

- A forensic examination is a medical examination that can only be conducted by specially trained doctors and nurses. The purpose of the examination is to collect any physical evidence that may be used as evidence against the alleged perpetrator if criminal charges are laid after a sexual assault has occurred.
- Specially trained doctors and nurses are available at all Sexual Assault Services to provide medical and forensic examinations for victims of sexual assault.
- The consumer who has disclosed the sexual assault should be able to consent to a forensic examination and make decisions about whether or not to proceed with making a report to the Police (assuming the consumer has been provided with the relevant information).
- However, the consumer may not have the capacity to make informed decisions at this time and a medical or forensic examination, although agreed to by the consumer, may not be in the consumer's best interest. In such instances a medical or forensic examination, if there are no obvious injuries, can wait until the person is able to give consent.
- The local Sexual Assault Service counsellor can advise on consent issues in this context and forensic examination timeframes.
- If the consumer decides to undertake a forensic examination, they can request that a person of their choice – such as a friend or social worker – supports them during the examination.
- It is important to remember that accessing medical care and undergoing a forensic examination does not mean that the consumer has to report the assault to Police or request further action.

KEY ACTIONS/POINTS FOR ACUTE INPATIENT

- Where the senior clinician is satisfied that a forensic examination can be performed as an addition to appropriate medical treatment, the procedure is a minor medical treatment to which a 'person responsible' can provide a valid substitute consent, provided there are no objections from the consumer.
- If the senior clinician considers there is no medical reason why an examination should be undertaken and the only reason for such an examination is the collection of forensic evidence, the procedure is not medical treatment and the 'person responsible' has no authority to consent to such an examination.

- In such circumstances, an application should be made to the Guardianship Tribunal for the appointment of a Guardian who is authorised to give (or withhold) consent to a forensic examination (see *Assessing Capacity* for further information).
- However, a sexual assault forensic examination will never be performed on a person who is unwilling to proceed with the examination, even if the necessary consent is obtained.
- Additionally, the consent for a sexual assault forensic examination does not include consent to release the Sexual Assault Investigation Kit (SAIK) to Police. It is preferable, where possible, to wait until the consumer can make their own decision about releasing the forensic protocol and proceeding with the report to Police.
- A decision about whether the consumer has recovered the capacity to make informed consent in relation to the release of the kit will be determined by the treating mental health practitioner and the consumer. The process and basis of this decision will be documented in the consumer's file.
- If the consumer does not recover the capacity to give informed consent, only a guardian appointed by the Guardianship Tribunal will have the authority to determine whether to release the SAIK or not.
- Due to the issue of re-traumatisation and the capacity for consent around complex issues it is recommended that consent not be given for the taking of photographs for forensic or educational purposes.

KEY ACTIONS/POINTS FOR NON-ACUTE/ RESIDENTIAL AND COMMUNITY

- Outside of the acute setting, consumers who have disclosed a sexual assault should be encouraged and supported to contact the local Sexual Assault Service or the local hospital, or to provide staff with permission to do so, regarding a forensic examination.

Assessing capacity to make informed decisions

Whether the consumer has the capacity to make informed decisions in relation to an incident of sexual assault or harassment, including reporting to Police, is an important consideration. The capacity to make informed decisions requires not only cognitive function, but also the ability to process information in a meaningful way.

KEY ACTIONS/POINTS FOR ALL SETTINGS⁶

- The treating team will need to evaluate:
 - The consumer’s capacity to understand the process of reporting an allegation to the Police, and what it might mean for them.
 - The consumer’s capacity to process and communicate information and effectively exercise their rights.
 - The consumer’s suitability to attend for Police interview and any likely detrimental effects on their mental health.
 - The consumer’s capacity to collaborate with an investigation.
- This will assist the senior clinician to form an opinion about the consumer’s wellness, the likely impact of Police interview on their mental state, and any other clinical considerations.
- However, individual values and beliefs can vary considerably from person to person and one individual’s decisions may not always appear rational to others. It is important that mental health staff do not judge a consumer as not competent to make their own decisions simply because they do not agree with their views or decisions.
- Basic principles to be used in assessing a person’s capacity include:
 - Always presume a person has capacity
 - Capacity is decision specific
 - Don’t assume a person lacks capacity on appearances
 - Assess the person decision making ability not the decision they make
 - Respect a person’s privacy
 - Substitute decision-making is a last resort (New South Wales Attorney General’s Department Capacity Toolkit May 2008 p. 27)
- It should also be noted that a consumer’s capacity may fluctuate, so decisions regarding what action to take in response to an incident of sexual assault or harassment should be delayed if possible until the consumer’s capacity is restored.
- If there are doubts about the consumer’s capacity to make an informed decision, a formal mental health assessment may be required.
- While a consumer may permanently lack the capacity to make medical decisions, they may still be able to

contribute meaningfully to a discussion about what actions they wish to take in response to an incident of sexual assault or harassment. The consumer’s nominated primary carer, if they have one and they are not the alleged perpetrator, can also support them with decision making.

- Special attention is required in the case of involuntary consumers under the Mental Health Act 2007.
- Involuntary status refers to the consumer’s capacity to consent to psychiatric treatment and does not automatically extend to a consumer’s capacity to make decisions about non-psychiatric medical treatment or other wellbeing or lifestyle matters.
- Where it is determined that an involuntary consumer does not have capacity to make an informed decision, urgent application can be made for a Guardian to make some decisions in the consumer’s best interests or the consumer’s ‘person responsible’ can be contacted.

5.1.2 When sexual assault or harassment is suspected but not disclosed

Sometimes staff may have a suspicion that sexual assault or harassment has occurred even when there has not been a disclosure by the consumer. While staff should be cognisant of the signs that could indicate this, it should be stressed that it is extremely difficult to tell, by observation alone, if someone has been the victim/survivor of sexual assault or harassment.

If a staff member suspects that a consumer has been sexually assaulted or harassed, it is important to ask the consumer directly (refer to Section 4).

Indication of possible recent sexual assault

Psycho-social

Psycho-social behavioural responses may occur immediately or within a few weeks of the sexual assault and may vary in their intensity, receding and intensifying at different times. Any individual might experience some, all or none of these responses and these will be expressed differently from one person to another. These responses could include:

- Significant changes in the consumer’s usual behaviour or affective state
- Acute stress response
- Avoidance of specific settings or individuals
- Withdrawal
- Sleep disturbances
- Changes to eating habits (e.g. refusing to eat)

⁶ Information adapted from the Victorian Government Department of Health Promoting sexual safety, responding to sexual activity, and managing allegations of sexual assault in adult acute inpatient units

- Regression
- Excessive crying
- Non-compliance or over-compliance

Physical

The incidence of physical injury related to sexual assault is low and the extent does not equate with the extent of psychological trauma. However, physical signs that may indicate a recent sexual assault include:

- Bruises, bleeding or other signs of physical trauma
- Foreign objects in genital, rectal or urethral openings
- Genital, urethral, or anal discomfort (e.g. itching, inflammation, infection)
- Sexually transmitted infection
- Torn or missing clothing
- Pregnancy
- Semen stains on clothing, particularly on women's clothing

Indication of possible prior sexual assault

For some people, their psycho-social reactions persist or worsen over time, or may appear some time after the assault or abuse has occurred. Some reactions that could indicate prior sexual assault include:

- Depression
- Flattened or hyper-aroused affect
- Flashbacks and/or nightmares
- Response to 'triggers' (i.e. any sensory stimulus that evokes a fear response related to a sexual assault)
- Substance misuse
- Atypical attachment
- Poor self-esteem, including body image issues
- Eating disorders
- Fear of a medical or dental examination
- Self-harming behaviour e.g. cutting, burning, head-banging, severe scratching
- Suicidality
- Sexually inappropriate behaviour
- Somatic health responses e.g. gynaecological problems, gastro-intestinal problems

Consumers who were sexually abused as children, or in other settings, may be retraumatised when they enter a new facility, or by events at a facility. Mental health staff should note the following 'triggers' that may suggest earlier sexual abuse, and may cause retraumatisation:

- Being out of control in a situation
- Derogatory or insensitive comments about people who have experienced a sexual assault
- Television and movie violence
- Seeing someone who looks like assailant
- People touching or standing close without permission
- Being hugged or touched by any adult
- Being in a vulnerable position or situation
- Sexual advances
- Reading or hearing about other sexual assaults
- Feeling that people are staring
- Action, smell, sound, that reminds the consumer of the assailant or the place where assaulted

Reasons for non-disclosure

Consumers may not disclose sexual assault or sexual violence for a number of reasons, including:

- Fear of disbelief, or blame
- Past negative experience of disclosure
- Impact on family and significant others

The relationship between the consumer who has experienced a sexual assault and the perpetrator can also influence disclosure as the consumer may have a sense of responsibility to protect the perpetrator.

KEY ACTIONS/POINTS FOR ALL SETTINGS

- If a staff member suspects that a consumer has been sexually assaulted they should gently ask the person and offer help.
- However, in some cases, the consumer may not wish to confirm they have been sexually assaulted, even if the staff member has reasonable evidence to suggest that such an event has occurred.
- The staff member should discuss what they have observed with the consumer and explain why they continue to be concerned about the consumer's health and safety. The consumer should also be advised that they have the right not to discuss the issue at the present time but that the staff member would be available at a future time should the consumer wish to speak with them.

- Educative information about sexual assault and harassment should be offered along with advice about the role of the local Sexual Assault Service and how to contact them.
- Support to contact the local Sexual Assault Service or another specialist support organisation should also be offered.
- Even if the consumer does not confirm that a sexual assault has taken place, the suspicion of sexual assault should be reported internally via the available mechanisms (see *Reporting and recording requirements* – page 66).

KEY ACTIONS/POINTS FOR ACUTE INPATIENT

- In an inpatient setting, the senior clinician has a duty of care to consider and act in the consumer's best interests. Staff should refer to the information within *Assessing capacity* to decide whether a consumer is able to make informed decisions about their options regarding a sexual assault.
- Where an involuntary consumer has been assessed by the senior clinician and the consumer does not have the capacity to make informed decisions in relation to a disclosure of sexual assault, the senior clinician has a duty of care to report the allegation to Police.
- Where an involuntary consumer has been assessed and does have capacity, their wishes must be respected, unless legislatively prohibited e.g. when the alleged perpetrator is a member of staff.

KEY ACTIONS/POINTS FOR NON-ACUTE/ RESIDENTIAL AND COMMUNITY

- Outside of the acute setting, the consumer's wishes must be respected. The senior clinician should however take the necessary steps to protect the consumer's interests should they change their mind over time.
- This may involve the senior clinician ensuring the incident is well documented and any objective evidence is collected and preserved should the person wish to proceed at a later date. The consumer should be fully informed about the actions that will be taken and the reasons behind them.
- Follow-up care should also be provided including ongoing counselling about the event to understand their wish not to report, and help them exercise their rights, which may still include a choice not to proceed with any further action.

5.2 Consensual sexual activity in an inappropriate context or setting

5.2.1 Understanding consent and capacity

When sexual activity occurs, in all cases it must be easily recognised as consensual, voluntary and mutual in nature and the persons involved must have given informed consent.

Consent exists only when a person freely and voluntarily agrees to engage in sexual intercourse and can only be said to be valid if the person knows what they are consenting to, and has a real option of saying yes or no. Additionally, most jurisdictions in Australia recognise that there is no consent where the person who has agreed or submitted to the sexual act does not have the capacity to understand the sexual nature of the act.

Other factors which might make a person's consent to sex invalid include:

- If a person does not really understand what is being asked
- If a person does not know they have the right to refuse sex
- If a person does not know how to refuse sex
- If a person is afraid to refuse sex
- If a person does not know that sex is not meant to be painful or uncomfortable
- If a person does not know that he or she is being exploited when a reward/incentive or payment for sex is used
- If a person does not know that some relationships are illegal, such as those within families, or between health staff and consumers.

It is important, therefore, for mental health staff to have an understanding of the capacity of the consumers under their care to consent to sexual activity. When this capacity is in doubt, an assessment should be undertaken of the consumer's clinical mental health status, communication skills and current level of knowledge and understanding regarding sexual and personal relationships.

Specific questions to be considered within such an assessment include:

■ **Is the consumer aware of the relationship?**

Is the consumer aware of who is initiating the sexual contact? Does the consumer believe that the other person is a spouse, or do they know the other person's identity and intent? Can the consumer state what level of sexual intimacy with which they would be comfortable?

■ **What is the consumer's ability to avoid exploitation?**

Is the behaviour consistent with formerly held beliefs or values? Moreover, does the consumer have the capacity to say no to uninvited sexual contact?

■ **What is the consumer's understanding of the parameters and impact of the relationship?**

If the consumer realised that the relationship may be time limited, can they describe how they will act if the relationship ends?

Further information regarding what the law in NSW says about consent is provided at Appendix C – Crimes Act 2000.

5.2.2 Staff attitudes

There are situations where consumers may be engaging in activities which other people view as morally wrong or not in the best interests of the individual.

Mental health staff are not expected to judge the rightness of any sexual activity that has taken place. However, they are expected to be sensitive to the possibility of assault and abuse, and to raise any concerns with their line manager or the senior clinician if they believe a consumer's behaviour is putting them at risk.

KEY ACTIONS/POINTS FOR ALL SETTINGS

- It can be difficult for staff to decide whether sexual activity involving a consumer is consensual or should be recognised as an assault. An assessment that is specifically about the consumer's abilities to understand sexual and personal relationships, and therefore provide informed consent, will support staff in this regard. This assessment must be recorded in the consumer's collaborative care plan and reviewed on a regular basis.
- When assessing whether consent has been provided, evidence of mutuality should also be considered to rule out coercion. Factors to consider could include:
 - both parties seeking each other out
 - spending spare time together

- shared resources
- shared leisure activities
- restriction of activities with other potential partners

- If the sexual activity is deemed to be assault or harassment, the guidelines for responding to sexual assault or harassment will need to be followed.
- Even where the sexual activity is deemed consensual, staff should be cognisant of the need to provide counselling or other additional care or treatment, for either the participants or those who have witnessed the activity, to avoid retraumatisation for those who have experienced prior sexual assault or harassment.
- Staff will also need to ensure that the sexual safety standards for the service are reiterated to the consumer and their families and carers as well as the requirement to adhere to these.

KEY ACTIONS/POINTS FOR ACUTE INPATIENT

- In this setting, care should be taken to ensure that the consumer or consumers involved understand that sexual activity is not supported due to the vulnerability of those in care.

KEY ACTIONS/POINTS FOR NON-ACUTE/RESIDENTIAL AND COMMUNITY

- Consumers in non-acute/residential and community settings have the same rights as the rest of the community to engage in sexual activity so long as both parties consent, demonstrate capacity to make decisions and any activity takes place privately.
- In a non-acute/residential setting, where one or both individuals lack the capacity to consent, mental health staff should work with these individuals to explore solutions. Where a sexual relationship is established, staff should monitor the general wellbeing of the consumers involved and attempt to obtain an understanding of how this relationship may be impacting upon their wellbeing.

5.3 Sexually disinhibited behaviour

When a consumer exhibits sexually disinhibited behaviour, it can be confronting and embarrassing for those who witness the behaviour, or for those to whom the behaviour may be directed. Reassurance should be provided to both the consumer who is exhibiting the behaviour as well as to the person or persons who may have been offended by this behaviour.

Sexual disinhibition can also impact on the consumer's existing intimate relationships, their self-esteem and their reputation – the consumer may take actions that they would not ordinarily take while in a well state, such as engaging or offering to engage in sexual activity with someone.

Staff should try not to overreact to the behaviour – a gentle and patient approach should be adopted, particularly where the consumer has dementia, as they will often be anxious and need additional reassurance.

If there is any real threat to the safety of other consumers or staff from the consumer exhibiting the behaviour, the emphasis must be on protecting others.

KEY ACTIONS/POINTS FOR ALL SETTINGS

- When sexually disinhibited behaviour occurs, it is important to give clear, simple and unambiguous feedback. Staff cannot assume that a consumer will recognise hints that their behaviour is not appreciated.
 - Staff should take the consumer who has exhibited the behaviour aside and gently yet firmly provide this feedback, which may need to include matter-of-fact advice regarding unspoken rules about appropriate social behaviour.
 - The consumer's understanding of what has been said should be checked by asking them to repeat the information. Staff should use this approach with care and sensitivity to avoid being interpreted as patronising.
 - If the consumer does not already have a plan in place to manage their disinhibited behaviour, this will need to be developed (see section 4.3 and Appendix L for further information). After an incident of sexual disinhibition, any existing management plan for the consumer/s involved should be reviewed and updated to take account of the need for further actions or strategies.
 - Staff will also need to ensure this updated plan is agreed with and communicated to all mental health staff involved in the consumer's care as well as to the consumer's family and carer so that the consumer is receiving a consistent message about their behaviour.
 - Where a consumer has engaged in sexual activity with someone other than their regular partner as a part of their sexual disinhibition, they may require counselling along with their family, carer or friends. They may also require sexual health advice or treatment.
- If a consumer has sexually assaulted another consumer, or been assaulted themselves, as a result of their sexual disinhibition, the protocols for responding to this type of sexual safety incident should be followed.

KEY POINTS – RESPONDING TO A SEXUAL SAFETY INCIDENT

Sexual assault and harassment

When there is disclosure or acknowledgement of sexual assault or harassment

- Key actions to take when a disclosure of sexual assault is made:
 - Acknowledge and affirm the disclosure
 - Explore the disclosure
 - Establish and maintain safety
 - Secure any evidence
 - Offer support and options
 - Assess capacity to make informed decisions
 - Organise medical care
- See Section 5.1 for further information, as well as Appendix I and J.
- In relation to reporting to the NSW Police Force, contacting the local Sexual Assault Service or informing the consumer's family or carer, the wishes of the consumer who has disclosed the sexual assault must be respected at all times, except where:
 - the alleged perpetrator is a NSW Health staff member; or
 - the consumer does not have the capacity to make an informed decision.
- The Child Protection helpline must be notified when there is risk of significant harm to a child or group of children.
- Relevant line managers must be informed of allegations involving NSW Health staff members.

When sexual assault or harassment is suspected but not disclosed

- Staff should be cognisant of the signs that could indicate that sexual assault or harassment has occurred. See Section 5.1.2 for further information.
- If a mental health worker suspects that a consumer has been sexually assaulted or harassed, it is important to ask the consumer directly. See Section 4 for further information.

Consensual sexual activity in an inappropriate context or setting

Understanding consent

- When sexual activity occurs, in all cases it must be easily recognised as consensual, voluntary and mutual in nature and the persons involved must have given informed consent.
- Further information regarding what the law says about consent is provided at Appendix C.

Staff attitudes

- Mental health staff are not expected to judge the rightness of any sexual activity that has taken place. However, they are expected to be sensitive to the possibility of assault and harassment.
- An assessment that is specifically about the consumer's abilities to understand sexual and personal relationships will support staff in this regard. See 5.2.2 for further information.

Sexually disinhibited behaviour

- When a consumer exhibits sexually disinhibited behaviour, staff should provide clear and unambiguous feedback about the inappropriateness of the consumer's actions in a gentle yet firm manner.
- A management plan will need to be developed to manage any further behaviour of this nature, which should be communicated to all staff as well as the consumer's family and carer – see section 4.3 and Appendix L for further information.
- If a consumer has sexually assaulted another consumer, or been assaulted themselves, as a result of their sexual disinhibition, the protocols for responding to this type of sexual safety incident should be followed.

Reporting and Recording

Appropriate reporting and accurate recording are an essential component of an effective response to a sexual safety incident that involves a mental health consumer.

6.1 Sexual assault and harassment

6.1.1 Reporting

Internal

When a sexual assault or harassment has been disclosed or reported, the incident must be reported as follows:



Note that the Senior Manager is responsible for coordinating the service response and ensuring follow-up is provided. A review should take place via Root Cause Analysis/Sentinel Events Review or Reportable Incident Brief (RIB) structures.

If the alleged perpetrator is a staff member

- In addition to the steps outlined above, if the alleged perpetrator is a NSW Health staff member:
 - A Reportable incident Brief (RIB) must be submitted within 24 hours to the Ministry of Health for sexual misconduct and for sexual assault allegations made against staff members.

- A decision must be made about whether the staff member’s name must be entered onto the NSW Health Service Check Register in accordance with the NSW Health Service Check register policy.
- The NSW Police must be informed of any criminal allegations against NSW Health staff members.
- The NSW Ombudsman must be notified of any allegations relating to sexual offences or sexual misconduct by NSW Health staff members where the alleged victim was under 18 years of age at the time of alleged conduct.

External

External reporting is required under the following circumstances:

If the consumer who has disclosed the sexual assault indicates that the perpetrator is a staff member

- To support transparency, all allegations of sexual assault of a consumer by a staff member must be reported to the NSW Police Force.
- The consumer will need to be advised of this and the rationale for taking this step so that they are not made to feel disempowered if this action is not in line with their wishes. However, there is no obligation for the consumer to lodge a formal complaint with Police against the staff member if they do not wish to do so.

If the consumer who has disclosed the sexual assault is under 18 years of age

- Any staff member that has a concern about any risk of significant harm to a child or young person needs to report their concern to the Child Protection Helpline (13 36 27). This risk of significant harm may include: any sexual intercourse involving a child under the age of 16 years; sexual assault, abuse or neglect of a child or young person; or any child or young person or class of children or young people who may be in contact with an alleged perpetrator.
- The summary below notes the steps to be taken when reporting:

- ✓ Complete the Mandatory Reporter Guide (MRG) tool to help you identify if there is **risk of significant harm**. You can access the MRG at <http://www.keepthemsafe.nsw.gov.au/home>. Hard copies of the MRG are also available at health workplaces.
- ✓ If you identify **risk of significant harm**, call the Child Protection Helpline on 13 36 27 (for mandatory reporters) or in an emergency, call 000.
- ✓ Health **Child Wellbeing Units** (CWU) provide advice to NSW Health workers on what action to take and who to talk to about concerns for children at risk.
- ✓ Contact child protection professionals at the CWU on **1300 480 420**:
 - if you are uncertain about what action to take
 - if you need help on how to use the Mandatory Reporter Guide (MRG)
 - to inform the CWU of concerns for a child or young person below the threshold for risk of significant harm
 - where the Mandatory Reporter Guide advises you to do so.

- If the report concerns a young person aged over 16 but under 18 years, the young person should be involved in the decision to report to the Child Protection Helpline and the process of reporting, unless there are exceptional reasons for excluding them. Staff should note that a young person may perceive sexual activity as consensual because of the way the other person involved has promoted it, even though the situation may be one of sexual abuse and exploitation. If the young person does not agree to the report being made, staff may still make a report and this information must be conveyed to Community Services, as they must consider the young person's wishes in any investigations and assessments.
- All concerns that a child or young person may be at risk of significant harm and action taken are to be documented in the consumer's health record.
- For any allegations of sexual assault by a NSW Health staff member against a person who was under 18 years of age at the time of the alleged assault (even if they are an adult now), the NSW Police must be notified.
- The NSW Ombudsman must also be notified of any allegations of sexual assault or sexual misconduct against current staff members where the alleged victim is under 18 years of age at the time of the alleged assault, regardless of where or when the alleged assault is said to have occurred, and the health service must complete an investigation in accordance with the NSW Ombudsman's requirements, and notify the Commission for Children and Young People as required.

If the consumer who has disclosed the sexual assault requests that the assault is reported to the Police

- All requests by the consumer to report the assault to the Police should be actioned, unless there is doubt

about their capacity to make an informed decision (see *Assessing capacity to make informed decisions* for further advice).

- Information should be provided to the consumer regarding reporting to Police to help them to decide whether or not this is how they want to proceed, and whether they wish to make a formal complaint or simply notify the Police that the incident has occurred. Appendix E provides relevant information for this purpose.
- In all circumstances, the wishes of the consumer in relation to making a Police report must be respected, unless the consumer indicates that the perpetrator is a staff member. In this circumstance, Police must be notified of the alleged incident to ensure transparency regardless of whether the consumer wishes to take this step, but a formal complaint does not have to be made by the consumer if they do not wish to make one.

If the consumer who has disclosed the sexual assault requests support from the local Sexual Assault Service

- All requests by the consumer to report the assault to the local Sexual Assault Service should be actioned.
- Information should be provided to the consumer regarding how the Sexual Assault Service can help them, including reporting to Police to help them to decide whether or not this is how they want to proceed.
- The local Sexual Assault Service can also provide information regarding legal and complaint options and help the consumer to explore these in relation to their own needs and circumstances and to move towards a decision that is best for them. Involvement of or consultation with the Sexual Assault Service is important as legislation and witness support

provisions may change; it is the role of the Sexual Assault Service to maintain up to date knowledge.

If the consumer who has disclosed the sexual assault requests support from the service to notify their family or carer

- The service can help the consumer talk to their family or carer about the assault, if they request this.
- However, consent is required for staff to take this action, regardless of whether the consumer is voluntary or involuntary, and must be clearly documented in the consumer's file.
- The Sexual Assault Service can also provide counselling to family and significant others – this may be a counsellor separate to the counsellor who sees the consumer if indicated. This intervention is concerned with ensuring that family is able to appropriately respond to the consumer and to provide trauma informed support.

6.1.2 Recording

The sexual assault incident needs to be clearly and accurately recorded in the file of the consumer who has disclosed the sexual assault and the alleged perpetrator's file. Documentation should comprise actual accounts of events using the consumer's own words and clear descriptions of behaviours wherever possible.

Terminology or language which can be interpreted in different ways should not be used (e.g. terms such as 'inappropriate' or 'suspicious').

File of the consumer who has disclosed the sexual assault

The consumer's file should record:

- Specific details including the nature, time and location of the allegation, any witnesses, the consumer's account.
- The consumer's clinical state including mental status, the effects of the assault, and any coping strategies used.
- That the consumer has been provided with information regarding their rights, action which may be taken and support available.
- Any management strategies implemented and their outcome (i.e. helpful or not).
- To whom the incident has been reported, the actions taken thus far and the wishes of the consumer in relation to reporting the incident to external agencies, such as Police or the local Sexual Assault Service.
- The Incident Information Management System (IIMS) notification number.
- A review of the consumer's current status using the MH-OAT Standard Measure 1B (SM1B) needs to be completed. (MH-OAT protocols require the completion of a SM1B in response to a critical incident.)
- Where the allegation relates to a NSW Health staff member, the consumer's file should not contain all the details but should provide a reference to the location of the information.

Subpoenaed Files

- Medical records staff need to be provided with clear information about the information to be provided if a consumer's file is subpoenaed for legal proceedings in response to a sexual assault investigation. In particular, Sexual Assault Communications Privilege must be considered. *(People who have experienced a sexual assault have certain protection against discussions with counsellors being obtained under subpoena by Defendants in criminal proceedings. The aim is to protect the confidentiality of sexual assault counselling, so as to encourage people who have experienced sexual assault to seek counselling, and to make them feel more confident about actually reporting sexual assaults – see Subpoenas PD2010_065)*
- Further, if the consumer's file is subpoenaed for some other reason, it should be noted that the consumer's file contains information of a sensitive nature that must not be provided except where the legal proceedings are relevant to the specific sexual assault and Sexual Assault Communications Privilege does not apply.
- Under Section 29 of the Children and Young Persons (Care and Protection) Act 1998 the protection of the reporter's identity must be considered by services when executing exchange of information requests, providing a response to court subpoena or responding to requests for public access to government information.
- Section 29 protects the identity of people who report concerns about children and young people to the Child Protection Helpline or to a Child Wellbeing Unit which sends the report on to the Child Protection Helpline. It also protects the identity of persons concerned in making the report or causing the report to be made. It is prohibited under this section to disclose the reporter's identity as well as any information from which the reporter's identity might be deduced.

- A local protocol for Medical Records staff must be developed to ensure there is a clear process for identifying issues associated with the use of medical files as evidence in legal proceedings.

File of the person who has been identified as the perpetrator of the sexual assault

Where the alleged perpetrator is a consumer, the following information is to be recorded in their file:

- Specific details including the time and location of the incident and any witnesses.
- Whether the alleged perpetrator has been informed of the allegation of sexual assault. (The alleged perpetrator should not be informed of the allegation immediately where this may compromise the investigation or the safety of the consumer who has experienced the sexual assault.)
- That the alleged perpetrator has been provided information regarding their legal rights including access to legal services.
- To whom the incident has been reported and actions taken thus far. This includes any medical response, who has been notified, Police involvement and what consent has been given.
- IIMS notification number.

Where the alleged perpetrator is a staff member, the following information is to be recorded by the Senior Manager and kept separately from the staff member's HR file:

- Specific details including the nature, time and location of the alleged incident and any witnesses, and when and how reported.
- Details of any action taken in response to the allegation, such as counselling to any of the parties, notifications to external bodies such as he NSW Police, Child Protection Helpline etc.
- Any advice or information from NSW Police or Community Services, including advice that the NSW Health investigation may commence.
- Details of any investigation, including any investigation plan, details of interviews with relevant parties, details of any risk assessments and related risk management decision, including decisions around the NSW Health Service Check Register.
- The investigation report and all other documentation created in relation to the investigation.
- Any submissions from the staff member.

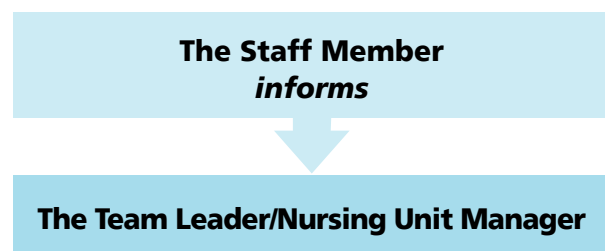
- Signed and dated File Notes must be kept of each telephone conversation, interview, notification sent and advice received during an internal investigation
- All e-mail correspondence.
- IIMS notification number.

6.2 Consensual sexual activity in an inappropriate context or setting

6.2.1 Reporting

Internal

When consensual sexual activity in an inappropriate context or setting has been disclosed or reported, the incident must be reported as follows:



External

External reporting of this type of sexual safety incident is not required.

6.2.2 Recording

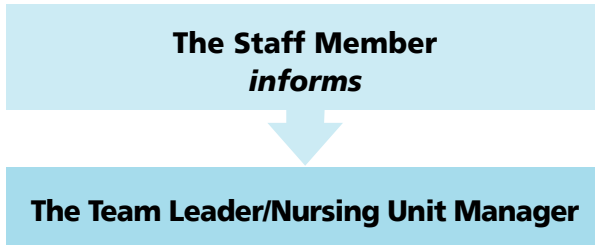
If the consumers involved in this type of sexual safety incident are both in an inpatient or residential setting, files for both consumers must have the incident documented in their files. Any action taken must be documented as well, including any increase in levels of observation, assessment of the consensual, voluntary and mutual nature of the sexual activity, counselling or education for consumer/s involved or debriefing with consumers who may have witnessed the incident.

6.3 Sexually disinhibited behaviour

6.3.1 Reporting

Internal

When sexually disinhibited behaviour has been disclosed or reported, the incident must be reported as follows:



External

External reporting of this type of sexual safety incident is not required.

6.3.2 Recording

The consumer's behaviour must be noted in their file due to their own and other consumer's vulnerability, and because of the need for an increase in levels of observation to enhance safety and minimise the risk of the occurrence of further disinhibited behaviour.

A plan to manage any future incidents should be developed and any actions taken must be documented including an increase in level of observation, debriefing with consumers around the incident and advice to the consumer, and their family and carer, about strategies noted within the management plan so that a consistent message is provided.

Highly vulnerable groups

7.1 Consumers who are Aboriginal and Torres Strait Islander

The prevalence of trauma such as sexual assault within the Aboriginal and Torres Strait Islander communities across Australia is relatively high. Yet non-Aboriginal staff often feel challenged and uncertain about the most culturally respectful and competent approach to effectively supporting Aboriginal consumers who have experienced sexual assault and violence.

Although it relates specifically to family violence in Aboriginal communities, the Aboriginal Family Health Strategy (http://www.health.nsw.gov.au/pubs/2011/aboriginal_family_health_.html) provides an example of the approach and specific considerations that would enhance service provision to Aboriginal consumers in relation to sexual safety. In particular, the Principles of Aboriginal Health, the Model of Care and the healing approach promoted by the Strategy, should be considered where appropriate.

One of the key tactics highlighted within the Strategy is the provision of clear, effective and culturally appropriate information for Aboriginal people. Mental health staff should consider sourcing culturally appropriate and sensitive material that supports advice to the consumer and family about responding to sexual assault and violence. Alternatively, services may wish to develop their own resources for the specific Aboriginal communities in their locality. The following NSW Health resources may provide advice and support in relation to this.

Communicating Positively

http://www.health.nsw.gov.au/pubs/2004/aboriginal_terms.html

Working with Aboriginal Communities

http://www.community.nsw.gov.au/docswr/_assets/main/documents/working_with_aboriginal.pdf

Relevant training for mental health staff will also be critical to enhancing cultural competence in responding

to sexual safety incidents involving Aboriginal mental health consumers. The Education Centre Against Violence (ECAV) provides a number of relevant courses including:

Defining healthy boundaries when working in Aboriginal communities

(<http://www.ecav.health.nsw.gov.au/ecav/index.asp?pg=2&s=C&cNo=175>)

This training is for Aboriginal staff who engage in supportive and healing relationships with Aboriginal clients and communities that have experienced family violence, child abuse, adult or child sexual assault.

NSW Health specialist Sexual Assault Services training

<http://www.ecav.health.nsw.gov.au/ecav/index.asp?pg=2&s=C&cNo=200>

Defines culturally competent responses to diverse population groups including Aboriginal or Torres Strait Island people and people of Culturally and Linguistically Diverse backgrounds.

Where possible, appropriately qualified Aboriginal Workers or Aboriginal Liaison Officers (within agencies e.g. hospitals, Police) should be engaged to work with consumers around appropriately preventing and responding to sexual safety incidents.

It is also vital that the Aboriginal status of clients is recorded accurately and consistently in order to develop and improve, monitor and evaluate services providing care and protection for Aboriginal children and families.

In general, Aboriginal status is poorly recorded in health related data and consequently the utilisation of services by Aboriginal clients is under represented. This in turn contributes to insufficient culturally appropriate and accessible service provision. See principles for recording Aboriginal and Torres Strait Islander origin information of consumers and clients

http://www.health.nsw.gov.au/policies/pd/2012PD2012_042.html.

7.2 Consumers who are children or young people

The Children and Young Persons (Care and Protection) Act 1998 defines a child as 'a person under the age of under 16 years' and a young person as 'a person who is aged 16 years or above but who is under the age of 18 years' (i.e. a person who is 16 or 17 years old). In addition, the minimum age of consent for sexual activity in NSW is 16 years old. The NSW Ombudsman defines children as being under the age of 18 years of age when dealing with allegations of sexual assault by staff members.

While children and young people may be vulnerable to sexual assault, they may also pose risks to other consumers, especially when exploring their sexuality and experimenting with sexual behaviour. Children and young people can display a continuum of sexual behaviour, where at one end they display healthy, age-appropriate sexual behaviour and at the other may in some circumstances engage in behaviours that are problematic or abusive.

Accordingly, mental health staff should not assume that an age-specific service is automatically safe. Appropriate risk assessment and mitigation will need to be undertaken in all service settings that cater to the needs of children and young people, including inpatient, rehabilitation and community-based services.

Communication is also a key factor in the sexual safety of consumers who are children and young people. Children and young people may be reluctant to communicate their experiences verbally, meaning mental health staff will need to adopt communication styles that allow the child or young person to feel safe to communicate in their own way.

Education about contraception and other aspects of sexual health and safety may support young consumers to better communicate about any sexual safety issue, and consideration of the educative needs of this group should be a routine part of comprehensive individually-tailored care planning and service delivery.

Family and carers, who play an integral role in the provision of care for this age group, can support children and young people to understand the sexual safety standards in place for the service and to speak up about any incidents of sexual assault or harassment they are subjected to or witness. However, staff must be cognisant

that the involvement of families and carers is subject to child protection requirements where these are an issue.

Mental health staff must also be aware that if they suspect, on reasonable grounds, that a child or young person is at 'risk of significant harm' from abuse or neglect, they must report these concerns to the Community Services' Child Protection Helpline. NSW Ministry of Health Information Bulletin *Keep Them Safe – Making a Child Protection Report IB2010_005* (http://www.health.nsw.gov.au/policies/ib/2010/IB2010_005.html) defines 'significant harm' as follows:

What is meant by 'significant' is that which is sufficiently serious to warrant a response by a statutory authority irrespective of a family's consent.

What is significant is not minor or trivial and may reasonably be expected to produce a substantial and demonstrably adverse impact on the child or young person's safety, welfare or wellbeing.

Keep Them Safe – Making a Child Protection Report IB2010_005 (http://www.health.nsw.gov.au/policies/ib/2010/IB2010_005.html) outlines the legislative requirements of NSW Health staff in protecting and supporting the safety, welfare and wellbeing of children and young people and reinforces the principle that care and protection of children and young people is a shared responsibility.

The *NSW Mandatory Reporter Guide (MRG)* assists NSW Health staff in deciding whether concerns for the safety, welfare and wellbeing of children and young people meet the risk of significant harm threshold (*NSW Mandatory Reporter Guide* - <http://sdm.community.nsw.gov.au/mrg/app/summary.page>).

NSW Health Child Wellbeing Units (CWU) provide advice to NSW Health staff on what action to take and who to talk to about concerns for children at risk.

Mental health staff should contact child protection professionals at the CWU on 1300 480 420:

- if they are uncertain about what action to take
- if they need help on how to use the Mandatory Reporter Guide (MRG)

- to inform the CWU of concerns for a child or young person below the threshold for risk of significant harm
- where the Mandatory Reporter Guide advises to do so.

Mental health staff should also familiarise themselves with the following contact information:

- Community Services' Child Protection Helpline for mandatory reporters – 13 36 27
- NSW Health Child Wellbeing Units – 1300 480 420
- NSW Health Keep Them Safe Website
<http://www.health.nsw.gov.au/initiatives/kts/index.asp>
- Department of Premier and Cabinet Keep Them Safe Website
<http://www.keepthemsafe.nsw.gov.au/home>
- NSW Ombudsman Child Protection in the workplace – responding to allegations against employees –
<http://www.ombo.nsw.gov.au/news-and-publications/publications/guidelines/child-protection>

7.3 Consumers from a culturally and linguistically diverse background

Mental health consumers from culturally and linguistically diverse (CALD) backgrounds who are sexually assaulted or harassed can face multiple layers of disadvantage due to a range of factors such as racism, the fear of bringing 'shame' to their family, and disconnection from their community.

Being able to effectively communicate about sexual safety issues is the first step in ensuring that the special needs of CALD consumers are taken into account. The NSW Health Care Interpreter Service can assist persons from CALD backgrounds who present with communication difficulties – refer to NSW Ministry of Health Policy Directive *Standard Procedures for Working with Health Care Interpreters PD2006_053*. (http://www.health.nsw.gov.au/policies/pd/2006/PD2006_053.html)

Should the NSW Health Care Interpreter Service not be able to assist in the provision of a language resource, the Translating & Interpreting Service (http://www.immi.gov.au/living-in-australia/help-with-english/help_with_translating/) may be called upon for assistance.

While the Transcultural Mental Health Centre is not an interpreting service, they may be engaged when specialist cross cultural assessment or consultation is required.

The Centre also provides limited clinical care and management and these services can be accessed through Local Health Districts.

Family members, carers and friends may volunteer to assist with interpreting during the reporting of an incident, and this is acceptable at the first point of contact and may be beneficial in establishing any immediate concerns.

However family and friends of the consumer who has experienced an assault are inappropriate substitutes for a professional interpreter in the long term and their interests may actually be different from or in conflict with those of the consumer. Accordingly, an interpreter service should be engaged as soon as practicable, and this advice should be provided to the consumer's family.

Culturally and linguistically appropriate information regarding sexual violence and victims' rights and services are also critical. Services will need to consider the literacy level of the consumer though and be prepared to explain the written information in a clear and concise way, highlighting relevant contact details and what support can be accessed.

Documents that may provide further support for mental health staff include:

- Multicultural Mental Health Plan 2008-2012 – PD2008_067 (http://www.health.nsw.gov.au/policies/pd/2008/pdf/PD2008_067.pdf)
- NSW Refugee Health Plan 2011-2016 – PD2011_014 (http://www.health.nsw.gov.au/policies/pd/2011/PD2011_014.html)

7.4 Consumers with Intellectual Disability

People with intellectual disability (ID) often have key deficits in adaptive behaviour such as social problem solving and social judgement that can contribute to the risk of sexual abuse or assault. When a person with ID also has a mental illness or disorder, this risk can be substantially increased. Social dislocation, fragmented care and lack of education about sexuality and sexually appropriate behaviour may also contribute to this vulnerability.

Basic sex education, tailored to individually suit the

communication and comprehension level of the consumer with ID, can help to combat this vulnerability by providing the consumer with the knowledge to understand the difference between normal sexual activity and sexual assault. Armed with this knowledge, consumers with ID can more effectively identify when they are being victimised and develop self-protective behaviours.

Consumers with ID will also benefit from being provided with clear advice about their rights in relation to sexual safety, such as their right to say 'no' to sexual activity.

As people with ID can lack the confidence to assert their rights even when they are aware of them, education will also be required to help consumers with ID learn how to ensure these rights are upheld. This in turn will support them to speak up should they experience a sexual safety incident.

While many adults with mild ID engage in fulfilling consensual sexual relationships, some people with ID will lack the capacity to make decisions in relation to this area of their life.

Consumers with ID will benefit from an assessment of their communication skills and current level of knowledge and understanding regarding sexual and personal relationships – see Section 5.2.1 *Understanding consent and capacity* – to ensure they have the capacity to consent to sexual activity. Further information regarding what the law in NSW says about consent is provided at Appendix C.

The capacity of consumers with ID to make decisions if they have been assaulted will also need to be considered – further information regarding this is provided under the heading *Assessing capacity to make informed decisions*, page 41.

7.5 Gay, Bisexual, Lesbian and Transgender Consumers

The underlying issue in managing sexual safety for Gay, Bisexual, Lesbian and Transgender (GLBT) mental health consumers is the impact of real or perceived homophobia and transphobia.

Homophobia is a term used to describe a range of negative attitudes and feelings towards homosexuality and people who are identified or perceived as being gay, lesbian or bisexual.

Homophobia can occur in obvious and subtle ways and can include:

- Cultural stereotypes about acceptable forms of conduct around GLB people that degrades their sexual orientation;
- Condoning homophobia by not addressing inappropriate language/behaviour by others;
- Discounting the severity and impact of a sexual assault/harassment incident between people of the same-sex, where a GLB person is involved, due to a misconception that the behaviour is less traumatic because of the gender of the perpetrator.

The impact of homophobic behaviours on GLB individuals can be devastating, reducing their sense of personal safety or increasing vulnerability to sexual incidents. For GLB people who have experienced unwanted sexual behaviours, fear or perceptions of homophobia may affect their willingness to disclose the incident, due to fears of receiving a lesser standard of support.

Transphobia refers to discrimination against transsexuality and transsexual or transgender people because they do not conform to or who transgress societal gender expectations and norms.

While many of the ways in which homophobia manifests itself can also impact on transgender consumers, there are additional issues to consider in relation to the sexual safety of this group, such as:

- The assumption that gender identity is a disorder and the individual's presenting issue.
- A misconception that gender identity and sexual orientation are the same. Gender identity and sexual orientation are two distinct issues. Transgender people can be heterosexual, gay, lesbian or bisexual.
- An inability to accept a transgender person's chosen gender. This can impact on transgender women's access to single sex spaces, thus increasing vulnerability; and increase the vulnerability of transgender men in male single sex settings.

Creating a culture of acceptance that normalises diverse sexual orientations and gender identities will assist in promoting sexual safety as well as encouraging openness in reporting sexual safety incidents. Mental health services can create safe and non-judgemental environments for GLBT consumers through actively

promoting the service's acceptance of diverse sexual orientations and gender identities, and having a clear protocol or policy in place that dictates the unacceptability of homophobic and transphobic behaviour from either providers or consumers.

7.6 Older consumers

While the ageing process may impact on their sexual health, older people continue to see sexual relationships as an important aspect of their life.

However, older people are often viewed by society as being physically unattractive, uninterested in sex and incapable of achieving sexual arousal. Mental health staff caring for older consumers need to challenge these societal attitudes within their service to avoid the inadvertent nurturing of professional responses and an environment that could:

- Discourage older mental health consumers from reporting or freely discussing sexual safety incidents
- Lead to an inappropriate categorisation and intervention of sexual activity / expression from an older mental health consumer; and
- Overlook the needs of older mental health consumers that are particularly vulnerable to sexual safety incidences, including people that are cognitively impaired, physically frail and/or with severe depression.

The sexual safety of older mental health consumers can also be impacted upon by dementia, which can be complicated by behavioural and psychological symptoms of dementia (BPSD). BPSD is an umbrella term for a diverse group of non-cognitive symptoms such as psychosis, depression, agitation, inappropriate sexual behaviour, restlessness, intrusiveness and resistance to care.

In aged residential care settings, it is common for older mental health consumers with a diagnosis of BPSD, and to a lesser extent with other diagnosis such as mania, to be referred to Specialist Mental Health Services for Older People (SMHSOP) when there has been a sexual safety incident. These sexual safety incidents generally relate to sexual activity such as masturbation in an inappropriate setting, sexually disinhibited behaviour such as disrobing and inappropriately touching nursing staff that are

providing care, and staff perceptions of older mental health consumers and sexual safety.

Managing these referrals in an environment with other older mental health consumers who are particularly vulnerable to sexual safety requires specialised intervention and an interagency approach.

Appendices

APPENDIX A	Example Standards of Behaviour for an Acute Inpatient Mental Health Service setting and a Non-acute Inpatient or Rehabilitation Mental Health Service setting
APPENDIX B	Charter of Victims Rights
APPENDIX C	Relevant standards and legislation
APPENDIX D	Information about support options for consumers who have experienced sexual assault
APPENDIX E	Information about reporting to Police for consumers who have experienced sexual assault
APPENDIX F	Example posters to promote Sexual Assault Services
APPENDIX G	Sexual Assault Screening Tool
APPENDIX H	Examples of sexualised behaviour by healthcare professionals towards consumers or their carers
APPENDIX I	Responding to a disclosure of sexual assault – key actions
APPENDIX J	Responding to a disclosure of recent sexual assault – quick checklist
APPENDIX K	Follow up medical exams required when a person has been sexually assaulted
APPENDIX L	Reporting process for an incident of sexual assault
APPENDIX M	Information about managing Disinhibited Behaviour

Example Sexual Safety Standards of Behaviour

Sexual Safety Standards of Behaviour for an Acute Inpatient Mental Health Service

All consumers involved with this mental health service are asked to adhere to the following standards of behaviour in relation to sexual safety.

Standard 1	I respect myself.
Standard 2	I treat others with respect, dignity and courtesy.
Standard 3	I do not engage in any sexual activity with another person while on the grounds of the service.
Standard 4	I do not try to talk someone else into engaging in sexual activity, or harass another person sexually.
Standard 5	I try to be aware of how my behaviour makes others feel, and will change my behaviour if someone tells me it makes them uncomfortable, or I will ask for help with this if I need to.
Standard 6	I respect the rights of others to space and privacy to fulfil their sexual needs through masturbation.
Standard 7	I understand that fulfilling my own sexual needs through masturbation must be conducted privately and discreetly.
Standard 8	I speak up if I have been hurt, harassed or assaulted either physically or sexually.
Standard 9	I speak up if I see or hear about someone else being hurt, harassed or assaulted either physically or sexually.

Example Sexual Safety Standards of Behaviour for a Non-Acute Inpatient or Rehabilitation Mental Health Service

All consumers involved with this mental health service are asked to adhere to the following standards of behaviour in relation to sexual safety.

Standard 1	I respect myself.
Standard 2	I treat others with respect, dignity and courtesy.
Standard 3	I only engage in sexual activity with another person when they have given their consent.
Standard 4	I do not try to talk someone else into engaging in sexual activity, or harass another person sexually.
Standard 5	I only engage in sexual activity with another person in the privacy of my own or the other person's room, or a room that is provided by the service, while on the grounds of the service.
Standard 6	I understand that sexual activity with another person should be for mutual pleasure, and never used for punishment.
Standard 7	I never intentionally hurt anyone when engaging in sexual activity with them, and I understand that I must stop engaging in sexual activity when the person I am with says 'stop'.
Standard 8	I always practice safe sex and use a condom when engaging in sexual activity with another person.
Standard 9	I try to be aware of how our behaviour makes others feel, and will change my behaviour if someone tells me it makes them uncomfortable, or I will ask for help with this if I need to.
Standard 10	I respect the rights of others to space and privacy to fulfil their sexual needs through masturbation.
Standard 11	I understand that fulfilling my own sexual needs through masturbation must be conducted privately and discreetly.
Standard 12	I speak up if I have been hurt, harassed or assaulted either physically or sexually.
Standard 13	I speak up if I see or hear about someone else being hurt, harassed or assaulted either physically or sexually.

Charter of Victims Rights

Extract from the Victims Rights Act 1996 – Part 2, Section 6

Courtesy, compassion and respect

A victim should be treated with courtesy, compassion, and respect for the victim's rights and dignity.

Information about services and remedies

A victim should be informed at the earliest practical opportunity, by relevant agencies and officials, of the services and remedies available to the victim.

Access to services

A victim should have access where necessary to available welfare, health, counselling and legal assistance responsive to the victim's needs.

Information about investigation of the crime

A victim should, on request, be informed of the progress of the investigation of the crime, unless the disclosure might jeopardise the investigation. In that case, the victim should be informed accordingly.

Information about prosecution of accused

A victim should, on request, be informed of the following:

- (a) the charges laid against the accused or the reasons for not laying charges,
- (b) any decision of the prosecution to modify or not to proceed with charges laid against the accused, including any decision for the accused to accept a plea of guilty to a less serious charge in return for a full discharge with respect to the other charges,
- (c) the date and place of hearing of any charge laid against the accused,
- (d) the outcome of the criminal proceedings against the accused (including proceedings on appeal) and the sentence (if any) imposed.

Information about trial process and role as witness

A victim who is a witness in the trial for the crime should be informed about the trial process and the role of the victim as a witness in the prosecution of the accused.

Protection from contact with accused

A victim should be protected from unnecessary contact with the accused and defence witnesses during the course of court proceedings.

Protection of identity of victim

A victim's residential address and telephone number should not be disclosed unless a court otherwise directs.

Attendance at preliminary hearings

A victim should be relieved from appearing at preliminary hearings or committal hearings unless the court otherwise directs.

Return of property of victim held by State

If any property of a victim is held by the State for the purpose of investigation or evidence, the inconvenience to the victim should be minimised and the property returned promptly.

Protection from accused

A victim's need or perceived need for protection should be put before a bail authority by the prosecutor in any bail application by the accused.

Information about special bail conditions

A victim should be informed about any special bail conditions imposed on the accused that are designed to protect the victim or the victim's family.

Information about outcome of bail application

A victim should be informed of the outcome of a bail application if the accused has been charged with sexual assault or other serious personal violence.

Victim impact statement

A relevant victim should have access to information and assistance for the preparation of any victim impact statement authorised by law to ensure that the full effect of the crime on the victim is placed before the court.

Information about impending release, escape or eligibility for absence from custody

A victim should, on request, be kept informed of the offender's impending release or escape from custody, or of any change in security classification that results in the offender being eligible for unescorted absence from custody.

Submissions on parole and eligibility for absence from custody of serious offenders

A victim should, on request, be provided with the opportunity to make submissions concerning the granting of parole to a serious offender or any change in security classification that would result in a serious offender being eligible for unescorted absence from custody.

Compensation for victims of personal violence

A victim of a crime involving sexual or other serious personal violence should be entitled to make a claim under a statutory scheme for victims' compensation.

Relevant standards and the legislative framework

Relevant standards

- UN Declaration – Rights of Disabled Persons
<http://www.un-documents.net/a30r3447.htm>
- UN Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care
www.un.org/documents/ga/res/46/a46r119.htm
- NSW Ministry of Health Charter for Mental Health Care in NSW
www.health.nsw.gov.au/pubs/2000/mhcharter.html
- National Statement of Rights and Responsibilities of Consumers of Mental Health Services
<http://www.health.gov.au/internet/mhsc/publishing.nsf/Content/pub-sqps-rights>

The legislative framework

Medical Practice Act 1992

- Section 71A of the Medical Practice Act introduces ‘reportable misconduct’, placing an obligation on doctors to report certain types of misconduct to the Medical Board. This requirement came into force on 1 October 2008.
- The reporting obligations are not general, but focus on three areas of serious misconduct, one of which is *sexual misconduct*.
- The misconduct to be reported is linked to the practice of medicine. Under current Board policy, it is an absolute rule that a medical practitioner who engages in sexual activity with a current patient/consumer is guilty of professional misconduct.
- Engaging in sexual activity with a patient/consumer following the termination of the doctor/patient relationship may also amount to professional misconduct, depending on the circumstances of each case. For more information refer to the Board’s policy on sexual misconduct.
www.mcnsw.org.au/resources/1034

Crimes Act 1900

<http://www.legislation.nsw.gov.au/fullhtml/inforce/act+40+1900+cd+0+N>

- The Crimes Act 1900 consolidates the Statutes relating to Criminal Law and regulates criminal law in NSW.
- Part 3 Division 10 relates to sexual assault offences.
- Section 66F refers specifically to people with a ‘cognitive impairment’, which is defined in the act as follows:

...a person has a **cognitive impairment** if the person has:

- (a) an intellectual disability, or
- (b) a developmental disorder (including an autistic spectrum disorder), or
- (c) a neurological disorder, or
- (d) dementia, or
- (e) a severe mental illness, or
- (f) a brain injury,

that results in the person requiring supervision or social habilitation in connection with daily life activities. Section 61H, (1A)

- Under Section 66F (2) the Act states that a person who has sexual intercourse with a person who has a cognitive impairment and who was responsible for the care of that person, whether generally or at the time of the sexual intercourse, is guilty of an offence. The maximum penalty for this offence is imprisonment for 10 years.

- The Act defines a 'person responsible for care' as follows:

... a person is **responsible for the care** of a person who has a cognitive impairment if the person provides care to that person:

- (a) at a facility at which persons with a cognitive impairment are detained, reside or attend, or
- (b) at the home of that person in the course of a program under which any such facility or other government or community organisation provides care to persons with a cognitive impairment.

The care of a person with a cognitive impairment includes voluntary care, health professional care, education, home care and supervision.

Section 66F, (1)

- Under Section 66F (3) a person who has sexual intercourse with a person who has a cognitive impairment, with the intention of taking advantage of that person's cognitive impairment, is guilty of an offence. The maximum penalty for this offence is imprisonment for eight years. Attempting sexual intercourse attracts the same penalties.
- Importantly, under Section 66F (5) consent is not a defence for sexual intercourse on the basis that in many of these cases it would be considered that the victim is incapable of giving informed consent.

Victims Rights Act 1996

<http://www.legislation.nsw.gov.au/sessionalview/sessional/act/1996-114.pdf>

- The purpose of this Act is to recognise and promote the rights of victims of crime. It establishes a Charter of Victim's Rights for the appropriate treatment of victims of crime by government agencies and those funded by government. This includes Police, health, welfare, prosecution and correctional services.
- This means that mental health staff have an obligation to take account of the Charter in the administration of their service when dealing with a victim of crime.
- The Charter is monitored by the Victim Services, Department of Attorney General and Justice' (<http://www.lawlink.nsw.gov.au/vs>).
- The rights outlined within the Charter have been included at Appendix A.

Health Records and Information Privacy Act

www.legislation.nsw.gov.au/fullhtml/inforce/act+71+2002+FIRST+O+N

- The purpose of this Act is to promote fair and responsible handling of health information by both the private and public health sector.
- Schedule 1 of this Act provides a set of Principles that pertain specifically to public health organisations. Health Privacy Principles (http://www.austlii.edu.au/au/legis/nsw/consol_act/hraipa2002370/sch1.html)

Children and Young Persons (Care and Protection) Act 1998

<http://www.legislation.nsw.gov.au/fullhtml/inforce/act+157+1998+FIRST+O+N>

- Health care staff, including mental health, are considered under this Act to be **mandatory reporters**.
- A **mandatory reporter** is someone who is required by law to make a report to the Department of Community Services (DoCS) if they have current concerns about the safety, welfare or wellbeing of a child. This includes concerns about the child or young person having been sexually abused or being at risk of being abused. Mandatory reporters face penalties for failing to make a report.
- A child is a person under 16 years of age and a young person is 16 or 17 years old. This is an important distinction because the Act has different provisions for children and young people.
- Mandatory reporting requirements only apply to children. Services can also report concerns they may have about the safety, welfare or well-being of a young person, but this is not a mandatory reporting requirement (Refer to Section 3 of the Act for definitions of children and young people.)

Crimes Act 2000

<http://www.legislation.nsw.gov.au/viewtop/inforce/act+66+2007+cd+0+Y/>

- Consent exists only when a person freely and voluntarily agrees to engage in sexual intercourse. The law states that a person is unable to give consent when they were:
 - asleep or unconscious
 - significantly intoxicated or affected by drugs
 - unable to understand what they are consenting to

- intimidated, coerced or threatened
- submitted to the abuse of authority of a professional or any other trusted person
- unlawfully detained, or held against their will.
- These laws do not generally apply to children and vulnerable people who, under the law, cannot be said to have consented because of their age and vulnerability.
- Vulnerable people include children less than 16 years of age and people with a cognitive impairment. A person has a cognitive impairment if they require supervision or social habilitation in connection with daily life activities, as a result of one or more of the following:
 - (a) an intellectual disability
 - (b) a developmental disorder (including an autistic spectrum disorder)
 - (c) a neurological disorder
 - (d) dementia
 - (e) a severe mental illness
 - (f) a brain injury.

Criminal Procedure Act 1986 No 2009 (Part 5 Division 2 – Sexual Assault Communications Privilege)

- This Act provides specific protections where there are criminal proceedings or in Apprehended Violence Order (AVO) matters.
- Health records are deemed to be privileged when the consumer receives counselling or mental health treatment in which confidential communications are made by the consumer to health staff; this includes health staff conversations about the consumer to another person based upon the consumer's communications.
- This legislation applies to any counselling or mental health treatment received either before or after an incident of sexual assault.
- The privilege that may be claimed in district or local court proceedings can at times be effectively used in other court jurisdictions arguing that it is not in the 'public interest' for the health records to be accessed by other parties or that it is not relevant to the current proceedings.
- Refer to NSW Health Policy on Subpoenas (PD2010_065).

Information about support options for consumers who have experienced sexual assault

If you experience sexual assault or harassment, you can:

Report to Police and access medical care and support You can choose to report right away. The Police will need to gather evidence of the assault, which will include a forensic medical examination. They can support you to access medical care (through the local Sexual Assault Service or your nearest hospital or emergency department) and counselling and can help with protection/ safety needs. They can also support you to make a statement but you don't have to do this right away if you're not feeling up to it.

Where possible a full forensic exam is most effective within 72 hours of the assault or within one week.

If you want to report to the Police, you can call 000 or contact your nearest Police station. You can ask to speak to a female officer.

Report to Police, access medical care and support, but request no further legal action You can choose to report to Police and access medical care, counselling support, and undergo a forensic medical examination (through the local Sexual Assault Service or your nearest hospital or emergency department), but withdraw your complaint at a later time if you feel unable to proceed.

Where possible a full forensic exam is most effective within 72 hours of the assault or within one week.

If you want to report to the Police, you can call 000 or contact your nearest Police station. You can ask to speak to a female officer.

Police can also help with protection/safety needs.

Access medical care and forensic exam if undecided about whether to report You can keep your options open by having a forensic medical examination and asking that the Sexual Assault Service store the evidence (for up to three months) while you decide if you want to proceed with legal action.

Where possible a full forensic exam is most effective within 72 hours of the assault or within one week.

You can contact your nearest Sexual Assault Service or go to your nearest hospital or emergency department – contact the Victims Access Line on 1800 633 063 or (02) 8688 5511 for referral to your nearest medical care facility where you can access a forensic medical examination.

Access medical care and support and not report assault to Police You can choose not to report to Police but still get a medical check done and access counselling support from the local Sexual Assault Service.

Medical care can involve dealing with the physical and psychological impact of the assault, as well as any concerns about pregnancy or sexually transmitted infections. Please note that morning after pills are most effective taken within 72 hours of the assault.

You can contact your nearest Sexual Assault Service or go to your nearest hospital or emergency department.

You could also see a general practitioner/ doctor if you don't want a full forensic exam. Women's Health Centres, Sexual Health Centres and Family Planning Clinics can also offer medical support/ follow up.

No medical care or reporting, but still access support You can choose not to report to Police or get a medical check done. This option does not include medical support or legal action.

For counselling support, you can still contact your nearest Sexual Assault Service or go to your nearest hospital or emergency department, the Victims Access Line on 1800 633 063 or (02) 8688 5511.

Information about reporting to Police for consumers who have experienced sexual assault

Things to consider when deciding whether to report an incident of sexual assault to police

- Sexual assault is a serious crime
- A complaint can be made at any time. It does not have to be straight away.
- You can have forensic evidence taken and decide about reporting later.
- If the assault happened in the past, or when you were a child, a statement can still be made. Sometimes Detectives have other information about the offender which may help build a case.
- When making a complaint you can take a support person as long as that person will not be a witness – the Detectives can assist in deciding this. You can ask to meet Detectives at another location initially although the statement will be taken at the Police Station. If walking into the Police Station feels difficult, you can ring the Crime Manager, or ask your mental health service to ring them, to arrange an easier way to make contact.
- If an interpreter is needed the Police will arrange this.
- You can ask to speak to a female Detective and if one is available that will be arranged.
- If making a formal complaint is too difficult but you would like Police to have information about the crime, an informal report can be made. This may help in other investigations.
- You have the right to withdraw a complaint at any time.

What will happen when you do report sexual assault to police

- The Police Duty Officer or Crime Manager will ask basic information and then call a Detective.
- If the assault was recent Police will, with permission, take you to the nearest sexual assault unit where sexual assault counselling, medical assistance and the collection of forensic evidence will, with your permission, be arranged.
- Detectives will determine what investigations will take place after taking your statement. This may take some time and the Detectives may ask for further information.
- The investigating Detective will provide their contact details and the case number and keep you, or your nominated representative, informed of progress. You can ring the Detective for updates, or ask your mental health service to do this.
- If the Detective can gather enough evidence, charges will be laid. Sometimes there is not enough evidence and there is no further action. This does not mean the Police do not believe you – it only means that they cannot prove 'beyond reasonable doubt' that a crime has occurred.

Source: NSW Rape Crisis Centre information sheet 'Sexual Assault in NSW'

Example posters on accessing support

Are you someone with a mental illness that fits into one of the following groups?

An adult sexual assault victim

An adult who was sexually abused as a child

A child or young person under the age of 18 years who has been sexually assaulted or abused

A parent, carer, friend or family of a sexual assault victim

If you need help and advice about sexual assault or abuse, you can contact the Sexual Assault Service in your locality.

<INSERT LOCAL SUBURB> **SEXUAL ASSAULT SERVICE**
02 <INSERT LOCAL SAS PHONE NUMBER>

Are you from a Culturally and Linguistically Diverse background? If so, you can also contact:

Community Relations Commission

1300 651 500

Telephone Interpreter Services (24hrs)

13 14 50

Transcultural Mental Health

1800 648 911

Services for Treatment & Rehabilitation of Torture & Trauma Services (STARTTS)

02 9794 1900

Are you a Koori person with a mental illness that needs information about sexual assault or abuse?

If you are an Aboriginal person that needs help and advice about sexual assault or abuse, you can contact the following services.

Sexual Assault Services for Aboriginal & Torres Strait Islander people

- Indigenous Women's Legal Centre & Contact Line 1800 39 784
- Wirringa Baiya Aboriginal women's Legal Centre, phone 1800 686 587
- Aboriginal and Torres Strait Islander Legal Services: www.nwjc.org.au

Aboriginal Community Liaison Officer or Aboriginal Support Person

- If you wish to talk to the police about a sexual assault, you can ask to speak with an Aboriginal Community Liaison Officer, who may be located in the Local Area Command.
- Police can also contact an Aboriginal Support Person if there is an Aboriginal Support Group or a list of Aboriginal Support persons located in that command.

Department of Community Services or Community Services Centre

- If you are an Aboriginal child or young person or are concerned that a child or young person has been sexually assaulted, you can make a report to the Department of Community Services by contacting the DoCS Helpline, phone 132 111.
- If you would like to speak to someone in person, you can go your local Community Services Centre where arrangements can be made for you to talk to an Aboriginal Caseworker.

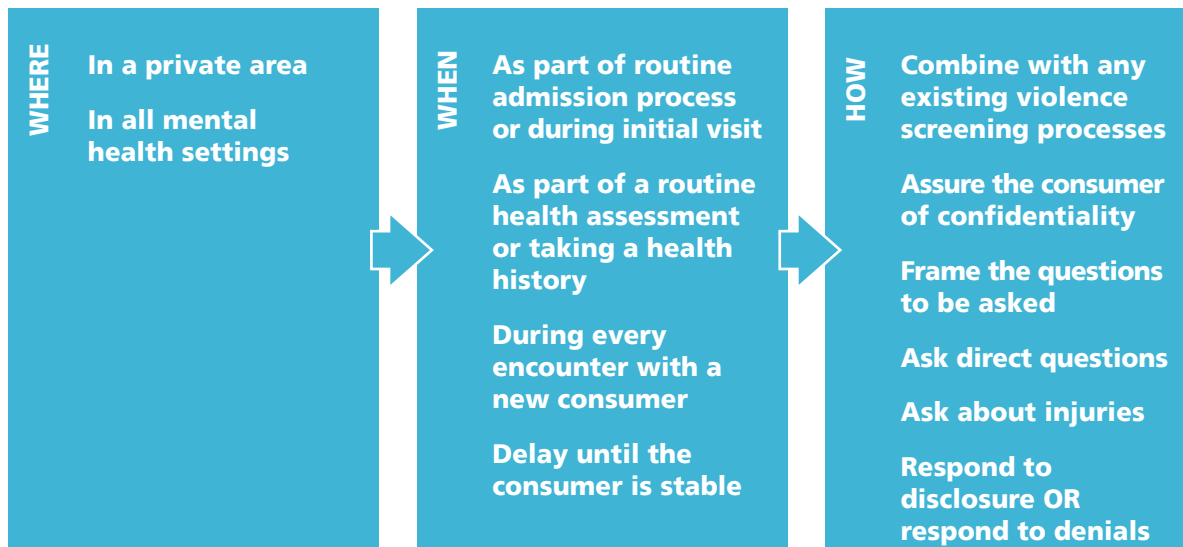
Centre for Aboriginal Health

- If you wish to speak to an Aboriginal counsellor in your area, you can contact the Centre for Aboriginal Health on (02) 9391 9502 about the availability of Aboriginal Family Health Workers, and/or Aboriginal sexual assault workers in your area.
- NSW health has specially trained counsellors who receive training to respond to the needs of victims of sexual assault.

Victims Services

- If you are an Aboriginal or Torres Strait Island person who is a victim of violent crime in NSW, like family violence or sexual assault you can call our confidential enquiry line on 188 019 123.
- The Witness Assistance Service of the Office of the Director of Public Prosecutions, has some Aboriginal Witness Assistance Officers, who can assist you if you have to go to court. Contact (02) 9285 2502 or 1800 814 534.

Sexual Assault Screening Tool



Assure the consumer of confidentiality: ■ Clearly state that any information shared will not be disclosed to the consumer’s carer or family.
■ Know your service’s responsibility regarding reporting sexual assault and take this into consideration when discussing the issue.
■ Assure the consumer that information provided will be kept confidential, except where the assault involves a child or young person, or where the alleged perpetrator is a health worker.

Frame the questions: ■ “So that I can work out the right way to support you while you are with our service, I need to know a bit more detail about your life before you came here, including any experiences you may have had that made you uncomfortable.”
■ “Because sexual assault is so common in many people’s lives, particularly people with mental health issues, we ask all our patients about it.”
■ “I don’t know if this is a problem for you, but many people we see are dealing with a past instance of sexual assault. Some people are reluctant to bring it up, so we always ask the question.”

Ask direct questions: ■ Are you in a relationship with someone who physically or emotionally hurts or threatens you?
■ Has your partner ever forced you to have sex when you didn’t want to or hurt you sexually?
■ Has a friend, a date, or an acquaintance ever pressured or forced you into sexual activities when you did not want them? Touched you in a way that made you uncomfortable? Anyone at home? Anyone at school? Anyone within this service? Any other adult?

Ask about injuries: ■ I notice you have a number of bruises (or other injury) - did someone do this to you?
■ Was it someone from home, like your partner or spouse? Was it someone from within this service?

Respond to disclosure:

- Allow the consumer to talk about it – listen non-judgmentally and validate the consumer's experience by conveying affirming messages that demonstrate sensitivity and compassion.
- Explore details of the assault (using open-ended questions only), if the consumer is comfortable to do this, and assess the consumer's mental state.
- Take steps to ensure the consumer's safety and secure any evidence if the assault is recent.
- Offer support and options for dealing with the assault, or set a time to discuss the assault further when the consumer is comfortable to do this.
- Assess the consumer's capacity to make decisions regarding reporting the assault or undertaking a forensic medical exam.
- Organise for the consumer to receive medical care and counselling as required.

Respond to denials:

- If the consumer denies any assault has taken place, but you still suspect it, let them know your concerns.
 - Make sure you provide the consumer with information about their options if they have been sexually assaulted.
 - Document your concerns in the consumer's file.
-

Examples of sexualised behaviour by healthcare professionals towards consumers or their carers

- ❌ Asking for or accepting a date
- ❌ Sexual humour during consultations or examinations
- ❌ Inappropriate sexual or demeaning comments, or asking clinically irrelevant questions, for example about their body or underwear, sexual performance or sexual orientation
- ❌ Requesting details of sexual orientation, history or preferences that are not necessary or relevant
- ❌ Internal examination without gloves
- ❌ Asking for, or accepting an offer of, sex
- ❌ Watching a consumer undress (unless a justified part of an examination)
- ❌ Unnecessary exposure of the consumer's body
- ❌ Accessing a consumer's or family member's records to find out personal information not clinically required for their treatment
- ❌ Unplanned home visits with sexual intent
- ❌ Taking or keeping photographs of the consumer or their family that are not clinically necessary
- ❌ Telling consumers about their own sexual problems, preferences or fantasies, or disclosing other intimate personal details
- ❌ Clinically unjustified physical examinations
- ❌ Intimate examinations carried out without the consumer's explicit consent
- ❌ Continuing with examination or treatment when consent has been refused or withdrawn
- ❌ Any sexual act induced by the healthcare professional for their own sexual gratification
- ❌ The exchange of drugs or services for sexual favours
- ❌ Exposure of parts of the healthcare professional's body to the consumer
- ❌ Sexual assault

Source: Clear sexual boundaries between healthcare professionals and patients – Information for patients and carers
Council for Healthcare Regulatory Excellence, April 2009

Responding to a disclosure of sexual assault – key actions

Key action	When the assault occurred in the last 7 days	When the assault occurred in the last 6 months	When the assault occurred in the past
Acknowledge and affirm the disclosure	✓	✓	✓
		If it is the first disclosure or the consumer has had previous negative experiences of disclosure, regardless of when the assault occurred, this may be a time of crisis for the consumer and staff may need to respond particularly sensitively.	
Explore the disclosure	✓	✓	✓
Establish and maintain safety	✓	✓	✓
Secure any evidence	✓	x	x
	Secure any evidence related to the sexual assault – keep any clothing removed by the victim/ survivor that they were wearing at the time of the assault, and secure the location of the assault if possible to prevent any evidence being disturbed.		
Offer support and options	✓	✓	✓
		A sexual assault can still be reported to the Police when it is not recent and the victim/survivor can still benefit from contact with the local Sexual Assault Service or other relevant counselling and support service.	
Assess capacity to make informed decisions	✓	✓	✓
Organise medical care	✓	✓	✓
	It is important that victims of sexual assault are offered medical assistance to treat any physical or psychological injuries, regardless of whether the assault was recent or occurred some time ago.		Consumers who were sexually abused as children, or in other settings, may be retraumatised when they enter a new facility, or by events at a facility. Mental health staff should note and be sensitive to ‘triggers’ in their work with consumers that may cause retraumatisation.

Step	Action	Information
1	Acknowledge and affirm the disclosure	Be non-judgemental, compassionate and understanding when a consumer discloses their experience of sexual assault or harassment and respond promptly, in accordance with the Sexual Safety of Mental Health Consumers Guidelines, whether the assault occurred prior to or after the consumer's admission.
2	Explore the disclosure	Provide the consumer with a safe, quiet, private space and gently encourage them to provide information about the assault. Ensure an assessment of the consumer's clinical mental state is undertaken within 24 hours in an acute inpatient setting and within 48 hours in all other settings before proceeding with next steps.
3	Establish and maintain safety	Assess whether the consumer is in current danger and the need for special accommodations to make the consumer feel safe, being mindful that it is the alleged perpetrator and not the consumer who has been assaulted that should be moved from the facility if required, unless the consumer who has disclosed the assault specifically requests otherwise or there are other extenuating circumstances.
4	Secure any evidence	Keep any clothing worn by the consumer at the time of the assault, ensure only the consumer handles these clothes, and secure the location of the assault if possible along with any CCTV footage of the area in which the incident occurred.
5	Offer support and options	Provide the consumer with advice and information regarding their options (Appendix D of the Sexual Safety of Mental Health Consumers Guidelines) so they can decide how they want to proceed. The consumer's wishes regarding how to proceed must be respected unless legislatively prohibited or they lack the capacity to make an informed decision (see Step 6).
6	Organise medical care	Encourage the consumer to seek immediate medical care to identify and treat any physical injuries and to discuss issues such as the risk of infection or pregnancy. Offer counselling as required and ensure consent is obtained for any forensic exam.
7	Assess capacity to make informed decisions	This assessment will need to include an evaluation of the consumer's capacity to understand their options, process and communicate information and effectively exercise their rights. If they are assessed as not having the capacity to make an informed decision regarding their options, any such decision should be delayed if possible until the consumer's capacity is restored. Alternatively, urgent application can be made for a Guardian to make some decisions.

Responding to a disclosure of recent sexual assault – quick checklist

Issues to be considered	Yes	No	Action required/taken	Date action taken
Is the consumer in current danger?	<input type="checkbox"/>	<input type="checkbox"/>		
Do special accommodations need to be made to make the consumer feel safe?	<input type="checkbox"/>	<input type="checkbox"/>		
Has any evidence related to the assault been secured?	<input type="checkbox"/>	<input type="checkbox"/>		
Does the consumer want a member of their family or their carer informed?	<input type="checkbox"/>	<input type="checkbox"/>		
Does the consumer want to report the assault to the Police?	<input type="checkbox"/>	<input type="checkbox"/>		
Does the consumer want to talk to a Sexual Assault Service or other counselling service?	<input type="checkbox"/>	<input type="checkbox"/>		
Has the consumer been assessed regarding their capacity to make an informed decision in relation to their assault?	<input type="checkbox"/>	<input type="checkbox"/>		
Does the consumer have acute injuries that need medical attention?	<input type="checkbox"/>	<input type="checkbox"/>		
Does the consumer want or need a forensic exam to be performed?	<input type="checkbox"/>	<input type="checkbox"/>		
If the assault happened within the past 120 hours, and the consumer is female, do they want or need emergency contraception?	<input type="checkbox"/>	<input type="checkbox"/>		
Does the consumer want or need prophylaxes for HIV or other sexually transmitted infections?	<input type="checkbox"/>	<input type="checkbox"/>		
Does the consumer want or need follow-up care, for either physical or psychological injuries?	<input type="checkbox"/>	<input type="checkbox"/>		

Follow up medical exams required when a person has been sexually assaulted

Follow-up medical exams are recommended at 2 weeks, 3 months and 6 months post assault. The local Sexual Assault Service can organise this, but if the consumer does not wish to involve anyone outside of the mental health service, staff will need to ensure these exams take place.

The 2-week follow-up exam – clinician will need to:

- Examine any injuries for proper healing.
- Photograph injuries if indicated (i.e. to document healing, comparisons in court). This should not include injuries to the genital area.
- Check that the consumer has completed the course of any medications given for STIs.
- Obtain cultures and draw blood to assess STI status, especially if prophylactic antibiotics were not given at the initial visit.
- Discuss results of any tests performed.
- Test for pregnancy if indicated. If pregnant, advise about options.
- Remind consumers to return for their hepatitis B vaccinations in 1 month and 6 months, other immunisations as indicated, and HIV testing at 3 and 6 months or to follow-up with their usual health care provider.
- Make follow-up appointments.
- Assess the consumer's emotional state and mental status, and encourage the consumer to seek counselling if they have not yet done so.

The 3-month follow-up exam – clinician will need to:

- Test for HIV. Make sure that pre- and post-testing counselling is available or make the appropriate referral. Assess pregnancy status and provide advice and support.
- Discuss results.
- Draw blood for syphilis testing if prophylactic antibiotics were not given previously.
- Assess consumer's emotional state and mental status and encourage the consumer to seek counselling if they have not yet done so.

The 6-month follow-up exam – clinician will need to:

- Test for HIV. Make sure that pre- and post-testing counselling is available or make an appropriate referral.
- Discuss results.
- Administer the third dose of the hepatitis B vaccine.
- Assess the consumer's emotional health and refer as necessary.

The above information is drawn from the World Health Organisation 2003 Guidelines for medico-legal care for victims of sexual violence, WHO, Geneva

Reporting process for an incident of sexual assault

Internally

- **To the Team Leader/Nursing Unit Manager, who must inform the Senior Manager.**
- **Through the Reportable Incident Brief (RIB) system** – RIB must be submitted within 24 hours when:
 - the alleged perpetrator is a staff member; or
 - the consumer who has been assaulted is under 16 years of age; or
 - the consumer who has been assaulted is over 16 but under 17 years of age and is in a care relationships with the alleged perpetrator.
- **Through the Root Cause Analysis (RCA) investigation process.**

Externally

To the NSW Police Force when:

- the consumer requests this and an assessment of the consumer’s clinical mental state does not preclude this as a relevant step;
- the alleged perpetrator is a staff member; or
- the consumer is under 16 years of age; or
- the consumer is over 16 but under 18 years of age and in a care relationship with the alleged perpetrator; or the consumer does not have the capacity to make an informed decision, and the senior clinician has a duty of care to formally report the assault.

To the Child Protection Helpline (13 36 27) when:

- the consumer is a child under 16 years of age. The Helpline must also be contacted if the consumer is a child at risk of significant harm (which includes when they have had consensual sexual intercourse); or
 - the consumer is over 16 but under 17 years of age and in a care relationship with the alleged perpetrator.
-

Information about Managing Disinhibited Behaviour

Talk about behaviour	<p>Educate and inform family, friends, staff about the behaviour and strategies to manage it.</p> <ul style="list-style-type: none"> ■ Talk to the person about their behaviour and what you expect. ■ Let them know if behaviour is not appropriate – if they don't know, they can't change it. ■ Let them know how the behaviour makes you feel e.g. 'I feel uncomfortable when ...' ■ Let other people know what strategies to use.
Provide feedback about behaviour	<p>Provide the person with frequent, direct and clear feedback. Feedback should:</p> <ul style="list-style-type: none"> ■ Be immediate and early ■ Be direct ■ Be concrete and describe the behaviour ■ Give direction ■ Be consistent ■ Not reinforce/encourage behaviour ■ Help the person to learn ■ Not be demeaning or humiliating ■ Not impose your own values
Manage the environment	<ul style="list-style-type: none"> ■ Try to predict situations where the behaviour is more likely to happen. ■ Work out strategies ahead of time to cope with the behaviour. ■ Restrict any opportunity to engage in inappropriate behaviour (planning, proximity, opportunity, means) ■ Limit any 'at risk' social activities e.g. crowded clubs or pubs or where alcohol is being consumed. ■ Provide cues re behaviour – what the person should/should not do – before, during, and after social activities. ■ Limit the amount of time a person spends in each situation. ■ Provide alternative activities e.g. small groups verses large groups. ■ Keep a comfortable distance so the person cannot touch, grab or get too close.
Provide supervision and structure	<ul style="list-style-type: none"> ■ Provide one-to-one support and supervision in any 'at risk' situations. ■ Provide cues and prompts about appropriate or inappropriate behaviour. ■ Redirect, distract or divert the person e.g. more appropriate topics of conversation, or change the activity or task.
Plan ahead	<p>If a person has a history of severe disinhibited sexual behaviour (exposure, masturbation in public, or sexual assault), it is essential that you plan ahead regarding personal safety.</p> <p>Consider:</p> <ul style="list-style-type: none"> ■ having two people provide care ■ limiting home visits ■ supervising children ■ limiting access to certain environments <p>In the person's home:</p> <ul style="list-style-type: none"> ■ Always visit with another person or make sure someone knows you are there when you visit. ■ Take a mobile phone with you, and carry it at all times. ■ Have your car keys in your pocket. ■ Get familiar with the home, so you know where the doors are located. ■ Keep a comfortable distance. For example, sit across a table, sit close to the door.

Adapted from the State of Queensland (Queensland Health) 2007 Acquired Brain Injury Outreach Service

References

- Abuse and Violence: Working with our patients in general practice* (3rd edition) (2008). South Melbourne: The Royal Australian College of General Practitioners.
- Acquired Brain Injury Outreach Service (2011). *What is disinhibited and inappropriate sexual behaviours?* Retrieved August 2011, from Queensland Health: <http://www.health.qld.gov.au/abios/>
- Agar, K, Read, J, Bush, J.M. (2002). 'Identification of abuse histories in a community mental health centre: The need for policies and training'. *Journal of Mental Health*, vol. 11, no. 5, pp. 533-543.
- Burgess AW, Holmstrom LL. Rape trauma syndrome. *Am J Psychiatry* 1974; 131:981-6.
- Carmody, M. (2003). *Sexual Ethics and Violence Prevention*. Social & Legal Studies, 199-216.
- Carmody, M., Evans, S., Krogh, C., Flood, M., Heenan, M., & Ovenden, G. (2009). *Framing best practice: National Standards for the primary prevention of sexual assault through education*, National Sexual Assault Prevention Education Project for NASASV. University of Western Sydney, Australia.
- Carmody, M., & Willis, K. (2006). *Developing Ethical Sexual Lives: Young People, Sex and Sexual Assault Prevention*. Sydney: University of Western Sydney, Social Justice Social Change Research Centre.
- Cook, B., David, F., Grant, A. (2001). *Sexual Violence in Australia*. Australian Institute of Criminology. ISBN 0 642 24205 4.
- Crome, S. (2006). Male survivors of sexual assault and rape (ACSSA Wrap No. 2). Melbourne: Australian Centre for the Study of Sexual Assault.
- Deegan, P. E. (2001). *Human Sexuality and Mental Illness: Consumer Viewpoints and Recovery Principles*. USA.
- Department of Health. Women's Mental Health: Into the Mainstream, Strategic Development of Mental Health Care for Women. (2002). Available at: www.dh.gov.uk/assetRoot/04/07/54/80/04075480.pdf
- Disability Discrimination Legal Service. (2003). *Beyond Belief, Beyond Justice: The difficulties for victim/survivors with disabilities when reporting sexual assault and seeking justice*. Melbourne.
- Evans I 2007, *Battle-scars: Long-term effects of prior domestic violence*, Melbourne: Centre for Women's Studies and Gender Research, Monash University.
- Ford, E., Rosenberg, M., Holsten, M., & Boudreaux, T. (2003). Managing Sexual Behavior on Adult Acute Care Inpatient Psychiatric Units. *PSYCHIATRIC SERVICES*, 54 (3), 346-350.
- Golding, J.M. (1999) 'Intimate partner violence as a risk factor for mental disorders: a meta-analysis', *Journal of Family Violence*, vol. 14, no. 2: 99-132.
- Goodfellow, J., & Camilleri, M. (2003). *Beyond Belief, Beyond Justice: The difficulties for victim/survivors with disabilities when reporting sexual assault and seeking justice*. Final report of stage one of the Sexual Offences Project. Melbourne: Disability Discrimination Legal Service.
- Goodman, L.A.; Rosenberg, S.D.; Mueser, K.T.; and Drake, R.E. Physical and sexual assault history in women with serious mental illness: Prevalence, correlates, treatment, and future research directions. *Schizophrenia Bulletin*, 23(4):685-696, 1997.
- Goodman, L.A.; Salyers, M.P.; Mueser, K.T.; Rosenberg, S.D.; Swartz, M.; Essock, S.M.; Osher, F.C.; and Butterfield, M.I. Recent victimization in women and men with severe mental illness: Prevalence and correlates. *Journal of Traumatic Stress*, 14:615-632, 2001.

- Goodman, L.A.; Thompson, K.M.; Weinfurt, K.; Corl, S.; Acker, P.; Mueser, K.T.; and Rosenberg, S.D. Reliability of reports of violent victimization and PTSD among men and women with SMI. *Journal of Traumatic Stress*, 12:587-599, 1999.
- Havig, K. (2008, January). The Health Care Experience of Adult Survivors of Child Sexual Abuse – a systematic review of evidence on sensitive practice. *Trauma, Violence & Abuse*, pp. 19-33.
- Jennings, A. (2004). *The Damaging Consequences of Violence And Trauma: Facts, Discussion Points, and Recommendations for the Behavioural Health System*. Alexandria, VA: National Association of State Mental Health Program Directors, National Technical Assistance Center for State Mental Health Planning.
- Kessler, R.C.; Crum, R.M.; Warner, L.A.; Nelson, C.B.; Schulenberg, J.; and Anthony, J.C. Lifetime co-occurrence of DSM-III-R alcohol abuse and dependence with other psychiatric disorders in the national comorbidity survey. *Archives of General Psychiatry*, 54:313-321, 1997.
- Kessler, R.C.; Sonnega, A.; Bromet, E.; Hughes, M.; and Nelson, C.B. Posttraumatic stress disorder in the national comorbidity survey. *Archives of General Psychiatry*, 52:1048-1060, 1995
- Inappropriate Sexual Behavior in Long-Term Care.
- Making choices Keeping safe Policy and Practice Guidelines on relationships and sexual wellbeing when working with people with learning disabilities*. (2004) UK. Lothian National Health Service.
- Mental Health ACT. (2009, January). Promotion of Sexual Safety/Prevention and Management of Sexual Assault in Bed Based Services Policy. ACT, Australia.
- McGee H, Garavan R, deBarra M, Byrne J, Conroy R (2002). *The SAVI Report*. Sexual Abuse and Violence in Ireland. A national study of Irish experiences, beliefs and attitudes concerning sexual violence. Dublin: Liffey Press, 2002.
- Mueser, K.T.; Goodman, L.B.; Trumbetta, S.L.; Rosenberg, S.D.; Osher, F.C.; Vidaver, R.; Auciello, P.; and Foy, D.W. 'Trauma and posttraumatic stress disorder in severe mental illness'. *Journal of Consulting and Clinical Psychology*, 66:493-499, 1998.
- National Disability Services WA. (2008). *Guidelines for the prevention and management of sexual abuse for disability service providers in Western Australia – An Information and Policy Resource*.
- 'National Executive Training Institute (NETI). (2005). *Training Curriculum for Reduction of Seclusion and Restraint*. Draft curriculum manual. Alexandria, VA: National Association of State Mental Health Program Directors (NASMHPD), National Technical Assistance Center for State Mental Health Planning (NTAC).
- National Sexual Violence Resource Center. (2011). *Assessing Patients for Sexual Violence – A Guide for Health Care Providers*.
- Paul Kettl, M. (2008). Inappropriate Sexual Behaviour in Long-Term Care. *Annals of Long-Term Care*.
- Petrak, J. (2002). The psychological impact of sexual assault. In J. Petrak & B. Hedge (Eds.), *The Trauma of Sexual Assault: Treatment, Prevention and Practice*. West Sussex: John Wiley & Sons.
- Powell, A. (2007). Sexual pressure and young people's negotiation of consent. ACSSA Aware Newsletter, 14, 8–16. Retrieved 31 July 2008. From <http://www.aifs.gov.au/acssa/pubs/newsletter/n14.html>
- Powell, S. M. (2008). Sexual assault and adults with a disability – enabling recognition, disclosure and a just response. *ACSSA Issues*, No. 9.
- Registered Nurses' Association of Ontario – Nursing Best Practice Guidelines Program. (2005). *Woman Abuse: Screening, Identification and Initial Response*. Toronto: Registered Nurses' Association of Ontario.

- Royal Australian College of General Practitioners – Quality Care and Research Unit. (2008). *Abuse and violence: Working with our patients in general practice (3rd edition)*.
- Simpson GK. & Orchison R (2006). Sexuality after traumatic brain injury: issues and strategies. In: Introduction to traumatic brain injury: a training kit. <http://www.tbistafftraining.info>
- Stepakoff, S. (1998). Effects of sexual victimization on suicidal ideation and behaviour in U.S. college women. *Suicide and Life-Threatening Behavior*, 28(1), 107–126.
- Taft, A. (2003), 'Promoting women's mental health: The challenges of intimate/domestic violence against women', Issues Paper 8, Australian Family and Domestic Violence Clearinghouse, Sydney. Available: www.adfvc.unsw.edu.au/PDF%20files/Issues_Paper_8.pdf
- Teasdale, B. (2009) 'Mental Disorder and Violent Victimization', *Criminal Justice and Behaviour*, Issue 36: 513-535.
- Urbis Keys Young for the Office of the Status of Women, Department of the Prime Minister and Cabinet. (2004). *National Framework for Sexual Assault Prevention*. ACT: Commonwealth of Australia.
- Victorian Women and Mental Health Network. (2009). *Increasing Safety and Gender Sensitivity in mixed sex psychiatric units*.
- Wahl, J. (2008). Sexuality in Long Term Care Homes – the Legal Issues. Toronto, Ontario, Canada.
- Warner, J., Pitts, N., Crawford, M. J., Serfaty, M., Prabhakaran, P., & Amin, R. (2004). Sexual activity among patients in psychiatric hospital wards. *Journal of the Royal Society of Medicine*, 97, 477-479.
- Woman Abuse: Screening, Identification and Initial Response – Nursing Best Practice Guideline*. (2005). Registered Nursing Association of Ontario, CAN.
- The Women's Health Council. (2007). *A Guide to Creating Gender-Sensitive Health Services*.
- The Women's Health Council. *Women's Mental Health: Promoting a Gendered Approach to Policy and Service Provision*. Dublin.
- Women's Centre for Health Matters Inc. (2009). WCHM Position Paper on Gender Sensitive Mental Health Service Delivery. Canberra.
- World Health Organization, International Consortium of Psychiatric Epidemiology. 2000. Crossnational comparisons of mental disorders. *Bulletin of the World Health Organization*, 78: 413-426.
- World Health Organization (2006). Gender disparities in mental health. Available at: www.who.int/mental_health/media/en/242.pdf. Accessed 9 July 2012.

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While every effort has been made to ensure the accuracy and reliability of the information in this document at the time of publication, it is the responsibility of users to check the currency of key documents, policies and procedures.

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