

Sexual health and safety guidelines

Mental health, alcohol and other drug services

2016

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Sexual Health and Safety Guidelines – mental health, alcohol and drug services
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Contents

1.	Purpose	1
2.	Scope.....	1
3.	Related documents	1
4.	Principles	2
5.	Background and development of the guidelines	2
6.	Sexual health	3
7.	Sexual safety	4
	7.1 What is sexual safety?.....	4
	7.2 Mental health alcohol and drug service responsibilities.....	4
	7.3 A service culture which promotes sexual safety.....	4
	7.4 Information for clients, family members and significant others	5
	7.5 Information, education and training for staff	6
8.	What are sexual safety incidents?	7
	8.1 Sexual assault	7
	8.2 Sexual harassment.....	8
	8.3 Consensual sexual activity in an inappropriate context or setting	8
	8.4 Sexual acts as a result of a client’s sexual disinhibition	9
9.	Preventing sexual safety incidents.....	9
	9.1 Risk assessment	9
	9.2 Risk mitigation	12
	9.3 Service environment and design.....	13
10.	Responding to disclosures of sexual assault	13
	10.1 Responding to disclosure of recent sexual assault.....	14
	10.2 Responding to disclosure of past sexual assault.....	16
	10.3 Considerations for clients under 18.....	16
	10.4 Other services which can provide assistance.....	17
11.	Responding to sexual activity	17
	11.1 Considerations for clients under 18.....	18
	11.2 Considerations for clients in extended treatment or community care units.....	18
12.	Vulnerable groups.....	19
13.	Sexual relationships between staff and clients.....	21



14. Privacy, confidentiality, documentation and record keeping	22
15. Service evaluation/monitoring of practice	23
16. References.....	24

1. Purpose

The Sexual health and safety guidelines – mental health, alcohol and other drug services 2016 (the Guidelines) provides information for mental health and alcohol and drug treatment services (Services) to:

- highlight sexual health as an important part of providing holistic care for clients
- improve recognition of factors impacting on the sexual safety of clients
- identify and appropriately respond to sexual safety risks
- appropriately respond to allegations of sexual assault
- establish a service culture which promotes sexual health and sexual safety
- facilitate development of local processes and procedures related to sexual health and sexual safety, which meet the needs of clients accessing the Service.

2. Scope

The Guidelines are intended for use in all Queensland public mental health and alcohol and drug treatment services, across all settings and age groups.

The information presented in the Guidelines is intended to embed sexual health considerations as a part of everyday care. It outlines potential sexual safety issues, thereby providing an evidence base and succinct information with which to guide the service response including service planning, employee education and training and development of tailored local response procedures.

3. Related documents

Queensland Legislation

- *Criminal Code Act 1899*
- *Anti-Discrimination Act 1991*
- *Child Protection Act 1999*
- *Public Health Act 2005*
- *Mental Health Act 2000*
- *Hospital and Health Boards Act 2011*
- *Information Privacy Act 2009*
- *Health Practitioner Regulation National Law (Queensland)*

Supporting documents/guidelines/standards

- National Standards for Mental Health Services (2010)
- National Safety and Quality Health Service Standards (2012)
- Response to sexual assault - Queensland Government Interagency Guidelines for Responding to People who have Experienced Sexual Assault (2014)
- Queensland Health Guide to Informed Decision-Making in Healthcare (2011)
- Queensland Health Service Directive Guideline for Clinical Incident Management (2013)

- Guideline for Reporting a Reasonable/Reportable Suspicion of Child Abuse and Neglect (2015)
- Guideline for Conducting Child Sexual Assault Examinations (2015)
- Queensland Sexual Health Strategy 2016-2021 (consultation draft)
- Aboriginal and Torres Strait Islander adolescent sexual health guideline (2013)
- Queensland Public Service Code of Conduct (2011)
- National Code of Conduct for Healthcare Professionals (Queensland, 2015)

4. Principles

Promoting sexual health and sexual safety, and responding to sexual assault and harassment in Services should be undertaken within a framework consistent with the following overarching principles:

1. The safety, and physical and psychological needs of clients are of paramount consideration.
2. The right of all clients to be treated with respect and dignity.
3. Clients have the right to receive services free from abuse, exploitation, discrimination, coercion, harassment and neglect.
4. Information is provided to clients in a manner that addresses issues of equity and access to ensure the individual needs of the client are met in regards to language, culture, age, disability, gender, sexuality and capacity.
5. Clients have a right to participate in decisions about their treatment and care. Informed decision making will be promoted, facilitated and respected at all times.
6. Clients' sense of personal control will be supported and encouraged.
7. Mental health and alcohol and drug treatment services utilise trauma informed care and practice when responding to reports of sexual safety incidents and promoting sexual health and safety.
8. Hospital and Health Services have a responsibility to ensure staff working in these services are provided with comprehensive education and training to enable them to effectively promote sexual health and sexual safety and respond appropriately to reports of sexual safety incidents.
9. All sexual safety incidents and allegations of sexual assault are reviewed, comprehensively documented and accurate records are kept. Documentation and records are prepared in accordance with legal and Queensland Health requirements, including obligations relating to privacy and confidentiality.

5. Background and development of the guidelines

The Guidelines supersede the 'Responding to sexual assault and promoting sexual safety within Queensland Health inpatient mental health services' guidelines, which were implemented in 2004 (2004 Guidelines). The 2004 Guidelines were developed following an expressed need from staff and consumers in sexual assault and disability sectors to prevent and address occurrence of sexual assault in inpatient mental health services.

Feedback provided to the Office of the Chief Psychiatrist, Mental Health Alcohol and Other Drugs Branch has identified a need to expand the scope of the 2004 Guidelines to cover alcohol and drug treatment services, all age groups, and both inpatient and community settings. For the purposes of the Guidelines, the term 'client' is used to describe an individual who is receiving treatment from a mental health and/or alcohol and drug treatment service.

The Office of the Chief Psychiatrist convened an Expert Reference Group to lead the review of the 2004 Guidelines, with the following sectors represented:

- adult mental health community, acute inpatient and extended inpatient
- high secure inpatient
- child and youth community and acute inpatient
- older persons community and acute inpatient
- alcohol and other drugs treatment community and inpatient
- Queensland Health Patient Safety and Quality Improvement Service
- Hospital and Health Service Child Protection Service
- Strategic Policy Unit, Department of Health
- Hospital and Health Service Sexual Health and Sexual Assault Services.

Further consultation was undertaken with the following stakeholder groups:

- Queensland Health mental health and alcohol and drug service clinicians
- Queensland Police Service
- Queensland Health Legal Branch
- Mental Health Alcohol and Other Drugs Branch.

6. Sexual health

The World Health Organization defines sexual health as 'a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.' (World Health Organization, 2016)

The sexual health needs of people accessing Services are often overlooked due to the focus on illness symptoms, substance use issues or functional impairment. Sexuality is a fundamental aspect of health and well-being for all individuals, but is often a difficult and sensitive subject to discuss, even in the most trusting relationships (S Esmail, 2010).

A holistic recovery-oriented approach to care in mental health alcohol and other drugs services addressing psychological, physical health, vocational and community connectedness often overlooks the sexual health needs of these clients. However, sexual health is an important consideration for our clients because they can be more vulnerable to poorer sexual health outcomes due to their illness, effects of medication and alcohol and drug use. Hepatitis C is commonly associated with IV drug use, and alcohol and drug use is a risk factor for unsafe sexual practices which can lead to sexually transmitted infections and blood borne viruses.

Conducting sexual health checks is an essential part of providing holistic care for clients. Staff should ensure the client's sexual health needs are met and link their clients to services which conduct relevant sexual health checks, including GPs. Clinicians are legally required to notify their local public health unit of sexually transmissible infections (STI) and blood borne viruses of public health significance. View the Australian STI Management Guidelines for more information www.sti.guidelines.org.au.

In Queensland, sexual health services are located at Brisbane, Redcliffe, Princess Alexandra Hospital, Gold Coast, Ipswich, Toowoomba, Sunshine Coast, Bundaberg, Rockhampton, Mackay, Townsville, Palm Island, Cairns, Mount Isa, Cape York, Bamaga and Thursday Island. These clinics offer specialised sexual and reproductive healthcare to all Queenslanders including priority population groups and may be hospital or community based.

7. Sexual safety

Ensuring sexual safety for Service clients requires all staff, clients, their families and carers to be well-informed about sexual safety, with everyone aware of their rights and responsibilities.

7.1 What is sexual safety?

Sexual safety is the recognition, maintenance and mutual respect of the physical, psychological, emotional and spiritual boundaries between people (New South Wales Ministry of Health, 2013). Services have a responsibility to protect all clients from the unwanted and inappropriate behaviours of others, and behaviours of their own that they might not choose to engage in when well (Victoria Department of Health, 2012).

7.2 Mental health, alcohol and other drug treatment service responsibilities

All Services have a responsibility to implement and monitor compliance with the Guidelines. Development of local policies and procedures should align with the Guidelines and take into account available evidence, the service setting, availability of local support services and be developed in consultation with clients, carers and their families.

7.3 A service culture which promotes sexual safety

Services are responsible for promoting sexual safety through operational policies and procedures which:

- support the client's right to physical and psychological safety
- encourage the monitoring of professional boundaries
- encourage and provide professional development for this subject matter
- provide guidance in responding appropriately to disclosures of sexual assault and/or breaches in boundaries.

Providing an environment that promotes sexual safety and prevents sexual assault encompasses a range of strategies for implementation by Services. These include:

- risk assessment including assessment of vulnerability
- identifying and responding to sexually disinhibited behaviour
- provision of a safe physical environment
- accurate record keeping, documentation and management when risks are identified

- adherence to policies and procedures that provide guidance for staff in responding to incidents
- access to relevant education/training and professional development
- conveying appropriate information to clients, family members and significant others.

Collaborative working relationships with Sexual Assault Response teams, the Queensland Police Service (QPS), child safety agencies, staff in the Service, clients and their families, where issues are addressed quickly and communication is open and factual, can assist with fostering a culture which supports sexual safety.

Strong clinical governance structures and processes are also a vital part in supporting sexual safety.

7.4 Information for clients, family members and significant others

Information for clients and visitors to Services will increase knowledge and awareness about appropriate behaviour and processes for reporting issues of concern, thereby facilitating a safer environment. Information should be provided to clients, family members and significant others in relation to the following areas:

- client rights and responsibilities
- what to do and who to speak to if a client has an experience with which they are uncomfortable, while in the Service
- what is expected from clients regarding their own behaviour in relation to the rights, privacy and safety of other clients, staff and other people visiting or accessing the Service
- other services, referral and support options
- the availability of interpreter services for clients from culturally and linguistically diverse backgrounds
- client rights in relation to complaints or grievances, and options to access support and assistance, including the right to independent advocacy support if a client chooses to make a complaint or grievance.

Information should be provided in a format that is accessible to and considerate of the diversity and developmental stage of individuals accessing the Service.

7.4.1 Empowering consumers

Irrespective of the setting in which care is provided or the illness acuity of the client, a critical component of promoting a culture which supports sexual safety includes empowering clients to participate in decision making activities regarding important areas of their lives. It is important that clients understand the link between sexual safety and sexual health (New South Wales Ministry of Health, 2013). Even the most unwell patient may be able to modify their behaviour if provided with information, counselling and support from staff (Victoria Department of Health, 2012).

Clients should also be provided with assistance to develop alternative ways of relating to people and developing relationships which are non-sexual, ethical and respectful to contribute to a culture of sexual safety.

7.4.2 Inpatient services

Information that should be provided to clients (refer to section 7.4) should be provided as soon as is practical following admission to an inpatient service; and where appropriate, the Service should prominently display information on a notice board or in an area that is accessible to all clients, family members and other relevant people accessing the service.

7.4.3 Community services

Staff providing services in the community can provide information and education regarding safe sex practices, to assist clients to understand coercion tactics and the meaning of sexual consent. Staff should endeavour to link clients to other services that meet broader sexual health needs, including GPs.

7.5 Information, education and training for staff

Education and information about issues affecting clients who have experienced sexual assault can improve the care delivered by staff. Many people accessing Services have a history of sexual assault and/or are vulnerable to sexual assault (Australian Institute of Family Studies, 2013). Female clients receiving alcohol and drug treatment services, in particular, have a high prevalence of sexual assault in early life (John Kelly, 2015). Staff need to understand the impact a history of sexual assault has on the client's presentation, interaction with people in authority and ongoing vulnerability. Education, training and supervision of staff is required to ensure a therapeutic response is provided to the individual. Additionally, training should enable knowledge about other services both internal and external to Services that can provide assistance and referral options for meeting the needs of people who have experienced sexual assault or have a history of abuse.

7.5.1 Induction and orientation

Services should ensure staff are provided with training and information as part of routine induction and orientation, and should include:

- sexual safety risk identification and its relationship to the broader risk assessment and trauma focused care framework
- planning and implementation of mitigation strategies to minimise sexual safety risks
- how to appropriately take a client's sexual assault history
- a staff member's role with regard to preventing sexual safety incidents
- integration of trauma-informed care principles into all aspects of clinical care
- gender-sensitive practices
- local governance procedures and escalation mechanisms.

7.5.2 Ongoing education and training

Services should create opportunities to:

- provide education and training regarding comprehensive assessment of risk
- provide information in relation to sexual assault and sexual safety at regular intervals in appropriate forums such as staff meetings or in-service training
- provide training for line managers to enhance skills in providing supervision to staff about sexual safety and organisational support for staff training

- provide access to existing policies and procedures in relation to sexual safety
- raise awareness about sexual assault, harassment and sexual safety by displaying appropriate materials either on a notice board, policy manual, on Service intranet pages, or in an area to which staff have access
- involve relevant local services in the delivery of training and information sessions about sexual assault and sexual safety
- train staff in taking a trauma history and the impact of trauma on mental health and interpersonal relationships
- provide staff with information regarding external education, training and professional development and support access to these opportunities.

Local policies should also acknowledge the impact on staff involved in responding to reports of sexual assault and caring for those who have experienced sexual assault, and ensure staff members are provided with information on the Employee Assistance Program.

Education and supervision may be required for staff in how to discuss sexual safety issues with clients, families and carers in a sensitive and non-sexualised way (New South Wales Ministry of Health, 2013).

Staff within acute inpatient settings may require additional information and training to conduct regular environmental audits which may assist in mitigating risks to sexual safety.

8. What are sexual safety incidents?

Sexual safety incidents can include but are not limited to the following:

8.1 Sexual assault

Sexual assault was made a crime under the *Criminal Code Act 1899*. Sexual assault refers to a situation where a person unlawfully and indecently assaults another person; or procures another person, without the person's consent:

- a) to commit an act of gross indecency; or
- b) to witness an act of gross indecency by the person or any other person (*Criminal Code Act, 1899*).

Sexual assault is a humiliating, degrading and terrifying experience, which can have long-term negative health and social effects on its victims. Victims experience a range of feelings including shock, fear, guilt, shame, depression and an inability to trust others.

People who have experienced sexual assault may have other words or ways of describing their individual experience of sexual assault. In some instances, victims may not identify their experience as sexual assault. In order to avoid further trauma, it is imperative that responses to victims are appropriate and sensitive. There are a range of other criminal offences in Queensland that are sexual in nature but for ease of reference, the Guidelines refer only to sexual assault¹.

¹ See Chapters 22 and 33 of the *Criminal Code Act 1899*.

8.2 Sexual harassment

Sexual harassment behaviour includes intimidation and predatory behaviour and is recognised as unlawful under the *Anti-discrimination Act 1991*.

Sexual harassment happens if a person:

- a) subjects another person to an unsolicited act of physical intimacy;
- b) makes an unsolicited demand or request (whether directly or by implication) for sexual favours from the other person;
- c) makes a remark with sexual connotations relating to the other person; or
- d) engages in any other unwelcome conduct of a sexual nature in relation to the other person;

and the person engaging in the conduct described above does so

- a) with the intention of offending, humiliating or intimidating the other person; or
- b) in circumstances where a reasonable person would have anticipated the possibility that the other person would be offended, humiliated or intimidated by the conduct. (*Anti-discrimination Act, 1991*)

Sexual harassment does not have to be repeated or ongoing to be against the law.

8.3 Consensual sexual activity in an inappropriate context or setting

Consensual sexual activity is any activity of a sexual nature (touching, intercourse, oral sex) that occurs between people over the age of 16² after mutual sexual consent has been provided by those involved, who are considered to have the capacity to consent.

The term 'inappropriate context or setting' refers to seemingly consensual sexual activity taking place in an environment or associated with a set of circumstances that is not considered by Queensland Health to be suitable, such as:

- an acute inpatient setting
- a public area of a non-acute, residential or rehabilitation unit
- when a staff member suspects that a client has been coerced into engaging in sexual activity or was unwell at the time that activity occurred.

The potential impact 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
- pregnancy
- vicarious trauma.

² In Queensland, anal sex with anyone under 18 is an offence.

Witnessing sexual activity, even if consensual, can be traumatic for others within the Service setting, particularly those that have previously experienced sexual assault or harassment (New South Wales Ministry of Health, 2013).

Staff have a duty of care to intervene in these situations. Sexual activity undertaken in an inappropriate context or setting within a health care environment should be responded to immediately with a safety management plan, discussion at a multidisciplinary team meeting, and escalation to senior management.

It is important for staff to be sensitive when dealing with these situations to ensure the parties involved do not feel demeaned, humiliated or exposed. As a general therapeutic principle, clients should be cautioned about the issues of forming relationships or making major life decisions whilst unwell (Victoria Department of Health, 2012).

Sexual activity in the health care setting or public environment should be considered an incident as defined under the Queensland Health Service Directive Guideline for Clinical Incident Management and be recorded on the local clinical incident reporting system.

8.4 Sexual acts as a result of a client's sexual disinhibition

Sexual disinhibition is an inability to restrain sexual impulses and involves behaviour or talk which is considered inappropriate for a particular environment. Behaviours can exist on a continuum and can escalate in severity, from an increase in sexual thoughts through to indiscriminate sexual activity (New South Wales Ministry of Health, 2013).

As a result of the impact of mental illness, clients may demonstrate sexually disinhibited behaviour. While demonstrating disinhibited behaviour, a client's ability to make informed choices and decisions may be impaired. Their behaviour may make them or other clients vulnerable to exploitation or abuse.

A client may find witnessing sexually disinhibited behaviour of another client to be traumatic, especially if they have a history of sexual assault and trauma. Staff should be cognisant of the impact of witnessing sexually disinhibited behaviour and provide support to the person witnessing the event, whether they are the client, family or visitor.

A safety management plan should be created for any individuals exhibiting sexually disinhibited behaviour, or have a history of sexual disinhibition. The event in which the person exhibited sexually disinhibited behaviour should be recorded as a clinical incident on the clinical incident reporting system, where appropriate.

9. Preventing sexual safety incidents

Risk assessment and plans for mitigating identified risks are crucial to preventing sexual assaults and harassment, and maintaining safety for clients, in all settings. Establishing a culture within the service in which clients are aware of the expectations on their behaviour can prevent incidents (see Use of treatment contracts under 9.2 Risk mitigation). Staff attitudes are also critical in identifying and preventing sexual safety incidents.

9.1 Risk assessment

Early identification of sexual safety risks is vital. In line with existing practices, and as part of a comprehensive overall mental health assessment, a risk screen should be undertaken for each client as soon as is practical following acceptance into the Service. The identification of risk should trigger a more detailed risk assessment where indicated. Information should be recorded on the

client's health record, alerts registered in the Consumer Integrated Mental Health Application (CIMHA) where necessary, and included in a documented care plan with regular review periods.

Like all domains of clinical risk, sexual safety risk assessment is a dynamic process undertaken both regularly and on an ad-hoc basis as the need is identified, either by changes in a client's presentation or by the actions of others.

A risk assessment should cover:

1. Potential to harm others, including the client's individual history of:
 - sexual violence
 - physical violence
 - cognitions supporting violence (including sexual violence)
 - threats and intimidation
 - impulsivity
 - predatory sexual behaviour
 - harm to others.
2. An assessment of risk to self, including the client's individual experiences of:
 - sexual assault
 - physical abuse
 - self harming behaviour
 - vulnerability
 - sexual disinhibition including early warning signs of at risk sexual behaviour
 - suicidality
 - absconding and non-compliance and how these issues may impact their sexual safety.
3. Non-client related risk factors, including:
 - the physical environment
 - the acuity of other clients within the healthcare environment with which they may have contact
 - level of staff supervision/observation available or provided
 - visitors to the mental health service.

An assessment of vulnerability should occur as part of the overall risk assessment and specifically consider the following:

- gender
- age
- sexual orientation and gender identity
- culture

- history of domestic or family violence
- history of being bullied
- intellectual disability or impairment
- developmental stage (particularly for clients under 18 years of age)
- physical disability (for example hearing impairment, vision impairment, physical impairment)
- communication (for example impairment as a result of disability, hearing impairment or English being the person's second language)
- cognitive impairment including, but not limited to dementia (D Probst, 2011), developmental disorders or acquired brain injuries
- behavioural and psychological symptoms of dementia
- potential effects of medication
- effects of mental illness, including psychosis
- alcohol and drug use (past and current)
- behaviour (for example sexual disinhibition, self-harm/harmful activities, risk taking behaviour, wandering).

9.1.1 Considerations for community clients

Clinicians working with clients of Services have a responsibility to consider the vulnerability of clients even in community settings. Clients have a right to enjoy a healthy and safe sex life. However, where a client's vulnerability puts them at risk of sexual assault or harassment, clinicians have a responsibility to consider their capacity to consent and intervene, where appropriate, if the client's safety is compromised.

A client's capacity to consent to sexual activity must be assessed and clinicians should inform their clients about the meaning of consent. Consent is an issue for both mental health and alcohol and drug treatment clients, although the factors contributing to their capacity to consent may differ. Consent must be freely and voluntarily given by a person with the cognitive capacity to do so.

Clients should be made aware that, as defined in the *Queensland Criminal Code 1899*, consent is not freely and voluntarily given if it is obtained:

- by force
- by threat or intimidation
- by fear of bodily harm
- by exercise of authority
- by false and fraudulent representations about the nature or purpose of the act
- by a mistaken belief that the accused person was their sexual partner (Criminal Code Act section 348, 1899).

Clients of mental health services may have impaired capacity resulting from their illness.

Alcohol and drug use may also impact on capacity to consent through the effects of intoxication on decision making. Decision making ability may also be compromised to some degree by their underlying substance use disorder, cognitive impairment or their withdrawal treatment.

Clinicians are encouraged to consider a client's capacity to consent when staff are made aware of sexual safety incidents. In circumstances where a clinician suspects the client was unable to freely provide consent to engage in sexual activity, further discussion with the multidisciplinary team should occur regarding the appropriateness of interventions to maintain the clients' safety.

9.2 Risk mitigation

Risk mitigation strategies for clients identified as vulnerable should take into account their clinical presentation, risks identified in the comprehensive risk assessment and the setting in which the client is receiving treatment. The following information is specific to identification and mitigation for sexual safety risks and does not address broader risk issues.

- Clients who are being treated in the community can have risks mitigated through education, information and linkage to appropriate support services.
- Staff should consider risk factors associated with discharging clients late at night, either from emergency departments or inpatient units, and mitigate this risk by securing safe transport (e.g. from a family member or provide the client with a taxi voucher).
- For inpatient settings, knowledge of a client's sexual orientation will help staff to accurately identify sexualised behaviour and may identify if the client could experience prejudice or harassment from other clients in the unit. This information could be obtained by conducting a comprehensive assessment including current and past relationships.
- Staff should consider the needs of transgender clients or clients with gender dysphoria, particularly with regard to their choice of gendered bathroom. The wishes of the client should be respected and accommodated where possible. This may include enabling the use of unisex or ambulatory bathroom options.
- Environmental security measures, such as the number of staff, frequency of observations and courtesy locks on doors can also be considered to mitigate risk of sexual safety incidents. Further issues about environment are discussed in section 9.3 of the Guidelines.

Clients can experience sexually abusive behaviour via technology such as smart phones and social media and it is important to consider this as part of the routine information and Service induction provided to clients, particularly children and young adults. ThinkUKnow is an evidence-based cyber safety program that provides accessible cyber safety education developed and delivered in collaboration with state and territory police services. Their website www.thinkuknow.org.au provides information about technology and youth, privacy, relationships and reputation management which may be useful for staff and clients.

Sexual safety risks and mitigation strategies should be discussed and routinely reviewed at multidisciplinary team meetings and documented in each client's record.

9.2.1 Use of treatment contracts

Inpatient services may consider using treatment contracts to address issues discussed in the Guidelines and mitigate sexual safety risks (noting a treatment contract would require an individual client having capacity to give informed consent to treatment).

Where possible, each client admitted to the inpatient unit would sign a treatment contract, wherein the client consents to abide by the unit rules to gain the maximum benefit from the inpatient program. In the contract, each client accepts that any behaviours specified in the contract (including sexual harassment or assault) will result in immediate interventions by staff to maintain the safety of others on the ward, or possible discharge from the service.

9.3 Service environment and design

Another important element of promoting sexual safety includes the design of Service environments. While it is acknowledged that the following considerations may not be able to be applied in all mental health and alcohol and drug services, it is important when developing or upgrading Services to consider the following factors:

- the placement of nurse stations/areas to enable effective and appropriate observation and support of clients when required
- gender specific bedrooms with proximity to nurse stations/areas to enable effective and appropriate observation and support of clients when required
- access to bathroom facilities as ensuites to bedrooms where possible
- gender specific bathrooms and toilets in separate areas where ensuites are not available
- access to safe and private space for all clients
- access to gender specific space for all clients
- recreational areas that vary in size to increase the capacity of clients to make choices about the degree of privacy they wish to have and facilitate their rights to be safe from intrusive behaviour
- visiting areas that facilitate privacy and safety.

9.3.1 Considerations for clients under 18 in adult inpatient units

Wherever possible, inpatient treatment for adolescents should be provided separately from adults. However in some circumstances this will not be possible and this may increase the risk.

In all situations when an adolescent is in an adult health service, environmental adjustments must be considered and particular care taken to plan, implement and document adequate clinical observation and supervision arrangements to ensure the young person's sexual safety. Transfer as soon as practical to an age specific Service should be a priority. Refer to Queensland Health guidelines regarding the admission of adolescents to adult mental health inpatient units for more information.

10. Responding to disclosures of sexual assault

Staff may become aware of an incident of sexual assault involving a client when:

- the client discloses they have been sexually assaulted, either recently or in the past
- the sexual assault or exploitative behaviour is observed by a third party
- the behaviour of the client changes significantly
- the client complains of physical symptoms or these symptoms are observed by another person.

Disclosure refers to telling another person about an incident of sexual assault or sexual harassment, or acknowledging to another person that this has occurred, whether the incident has occurred recently, in the past or is ongoing (New South Wales Ministry of Health, 2013).

Clinicians must be aware that disclosure or acknowledgement of sexual assault or harassment is a different process from making a report or an allegation of an assault – however sometimes they can be one in the same. Staff should be guided by the following:

- A client may disclose an experience of sexual assault to seek support from staff.
- A desire to report the assault formally to law enforcement agencies may occur during a disclosure.
- Regardless of whether a client chooses to formally report the assault, the disclosure should be discussed with the treating team, documented in clinical notes and the clinical incident reporting system (when a disclosure meets the definition of a clinical incident).
- Staff should provide information regarding the client's options to notify the police and facilitate this to occur if requested.
- The client's choice should be respected and supported.

A client may choose to retract a disclosure; however this does not mean a sexual safety incident did not occur. A risk assessment should still take place and the risk management plan reviewed by the multidisciplinary team and updated in the client's health record.

Refer to the Queensland Government Interagency Guidelines for Responding to People who have Experienced Sexual Assault to facilitate best practice, quality service provision across various government agencies where relevant.

If the disclosure involves allegations of sexual misconduct by a practitioner in connection with the practice of the practitioner's profession, then mandatory notification to the Office of the Health Ombudsman may be required for registered health practitioners. (*Health Practitioner Regulation National Law (Queensland), 2014*)

10.1 Responding to disclosure of recent sexual assault

Victims of sexual assault require access to services that are sensitive to, and can respond appropriately to their needs. In responding to a disclosure of sexual assault the following should be addressed: prioritising the safety, medical and health needs of the individual; options for pursuing justice; and ongoing emotional needs for long term wellbeing (Queensland Government, 2014).

More specifically, when a client discloses an alleged recent sexual assault staff should:

- Ensure the safety of the client first.
- Determine if the client requires an interpreter or similar assistance to ensure their understanding of issues that will be discussed with them, and arrange for this assistance to be in place throughout the process.
- Contact specialist hospital Sexual Assault Support Service staff to provide the immediate response to the client, where available.
- Advise the client that they are entitled to access a support person of their choice and facilitate this to occur. This person may be a partner, friend, community support worker, nurse, counsellor, family member, consumer or carer worker, or advocate.

- Take reasonable steps to accommodate the client's expressed gender preference for personnel.
- Advise the client that they are entitled to speak with a doctor and have a general medical examination, advice and preventive treatment.
- Advise the client that the QPS may request a forensic medical examination be conducted and the client has the right to choose if they want this examination to occur or not. If the client wishes to have this examination, explain the purpose of avoiding showering, changing clothes, going to the toilet, eating or drinking (where appropriate), recognising the need to provide a balance in relation to the client's needs. If the client is too uncomfortable or traumatised they may need to wash. This should be respected and supported.
- Provide information regarding the client's options to notify the QPS and facilitate this to occur if requested. If a client is undecided about whether or not to proceed with legal action, information should be provided and/or arranged regarding the implications of whatever decision is made. When QPS officers attend the Service, the officers and the staff of the Service should operate in a collaborative manner.
- Guide the client through each stage of the process by providing information one step at a time and allowing the client time to understand and consider the information being provided.

While supporting the client through the process of making a disclosure and acknowledgement of a sexual assault, staff should allow the client to talk about the experience in their own words, at their own pace. It is essential that staff believe and validate the clients' experiences (New South Wales Ministry of Health, 2013).

Ensure documentation of the incident reflects the client's own words. Staff should also be aware that if a client reports a sexual assault to staff prior to making a report to the QPS and the matter proceeds to court, staff may be called as a 'preliminary complainant' and their documentation about the incident may be used during court proceedings.

Staff are not expected, and should not attempt, to investigate reports of sexual assault. Staff must remember all people respond differently to trauma; and therefore not make assumptions or inferences about the incident.

Clinicians should document the alleged sexual assault in the clinical incident reporting system as soon as possible after caring for the client.

A client who has made a disclosure of sexual assault or harassment while an inpatient should receive assistance at the time of the incident. Following a disclosure, to reduce the risk of further psychological and/or physical trauma, information and assistance to access appropriate support, service information, and referral options should be provided to the client, and the client should be supported to engage with these services prior to discharge. The details should be documented in the client's health record.

When allegations are made against a staff member, the staff member should be supported to a private space away from the client and provided with information and assistance regarding their support needs and legal rights. See section 13 for more details.

When allegations are made against another client of the service, that client should be supported to a private space away from the person making the allegation and provided with information and assistance regarding their support needs and legal rights.

10.1.1 Forensic considerations

It is imperative that healthcare professionals respond to the immediate health and sexual health needs of the individual as a first priority to assess, treat and document injuries. Service staff should be aware of how to access a forensic pathway of care, including specialist forensic medical assessment. The victim of sexual assault has the right to information about a forensic medical examination and the right to accept or decline a forensic examination and to change that decision. For adults, the forensic medical examination is performed by a trained forensic medical officer, forensic nurse examiner, or appropriately trained doctors and nurses. For children, all health services have a role in providing an immediate response to children and young people up to 18 years of age who have experienced sexual assault. Where the child is under 14 years of age, following initial emergency medical treatment to assess and treat injury, a paediatrician may perform a forensic medical examination. For further detail on this, refer to the Queensland Health Guideline for Conducting Child Sexual Assault Examinations.

10.2 Responding to disclosure of past sexual assault

Understanding the impact of past sexual assault on the emotional and physical wellbeing of the client can assist in developing appropriate and relevant treatment and care plans. A good understanding of these factors will inform a more effective care plan by ensuring identification of the issues and underlying symptoms.

A range of preconditions exist to reduce further trauma to the client. It is essential that the clinician demonstrates:

- a knowledge and understanding of the issues and impact of sexual assault
- an ability to demonstrate acceptance, belief and acknowledgement of the client's experience. Regardless of whether staff suspect the client's disclosure may be a result of symptoms of their mental illness, the emotional and possibly physical distress the client is experiencing is very real for them
- understanding that it is not necessary to encourage people to go into details about the assault
- understanding that the client may not wish to engage in treatment specifically regarding the assault/s
- an ability to provide follow up and ongoing support either within the Service or through access to external service providers
- awareness of triggers that may be distressing for the client, including triggers that may occur during routine health care treatment or treatment of the clients' mental illness or problematic substance use.

10.3 Considerations for clients under 18

Communicating with children and young people about sexual safety matters can be challenging and will require staff to utilise a variety of communication strategies and therapeutic approaches. Families, carers and other support people perform an important role in supporting young people to understand sexual safety messages and encourage disclosure when incidents of sexual assault or harassment occur.

Where a client of a mental health service who is under the age of 18 years, discloses an allegation of sexual assault or sexual harassment, staff should be guided by the statutory requirements under the *Child Protection Act 1999* and the *Public Health Act 2005*.

It is acknowledged that the issue of sexual safety within child and youth mental health services is complex and multifaceted. Conflict may arise in relation to the wishes of the client, the expectations of parents and the obligations on staff when reporting or responding to allegations of sexual assault and/or sexual activity.

In these circumstances staff are encouraged to refer to their local policies and procedures, which should be consistent with existing legislation and statewide policies and guidelines. The service response should include comprehensive documentation about the incident, the client's expressed wishes – for example, to report, advise parents – and the actions taken by the clinician or Service.

10.3.1 Suspicion of child sexual abuse

Section 13E of the *Child Protection Act 1999* states a doctor and a registered nurse are legally mandated to report if they have a reasonable suspicion that a child has suffered or is suffering, or is at an unacceptable risk of suffering, significant harm caused by physical or sexual abuse and may not have a parent able and willing to protect the child from harm.

Staff members should inform Child Safety Services in accordance with s13A of the *Child Protection Act 1999* where the staff member reasonably suspects:

- a) a child may be in need of protection; or
- b) an unborn child may be in need of protection after he or she is born.

For further information including guidelines on recognising, responding to and reporting suspected child sexual abuse refer to the Queensland Health Child Safety Unit intranet home page. The Child Protection and Forensic Medical Service based at Children's Health Queensland Hospital and Health Service has a statewide clinical leadership role in the area of child protection education, training and research.

10.4 Other services which can provide assistance

Where available, access your hospital's Sexual Assault Support Service for specialist care from experienced and trained support staff.

The Department of Communities, Child Safety and Disability Services allocates funding to non-government organisations to assist victims of sexual assault. These sexual assault services offer flexible, holistic support including advocacy, and sexual assault and crisis counselling.

Victim Assist Queensland provides access to specialised support services and financial assistance for victims of personal acts of violence including sexual assault and provides information, referrals and support to victims, including assistance in making a victim impact statement (Queensland Government, 2014).

11. Responding to sexual activity

At times clients in either inpatient or community settings may have impaired judgement due to their illness, medication or while under the influence of drugs or alcohol. Clients in these circumstances may be unable to understand the nature of mutually consensual and respectful sexual relationships and therefore may be unable to make decisions regarding relationships or give informed consent to

a sexual relationship. It is important for clients to understand and acknowledge that consent to a relationship does not automatically confer consent to a sexual relationship or activity.

People's attitudes about sexual expression are varied and impacted by many different societal, religious and cultural factors. Therefore, it can be difficult for staff to make assessments about the 'appropriateness' of sexual behaviour exhibited by clients. Irrespective of diverse beliefs regarding sexual expression, clear appropriate standards of behaviour are required within public health facilities.

The local Hospital and Health Service policies and procedures for sexual safety should define acceptable standards for behaviour in inpatient units. The policies and procedures should take into account the setting (acute versus extended treatment), focus on maintaining a pro-social environment, and consider both the contextual factors and clinical impression of an increase in sexualised behaviour. Sexual activity is a normal and healthy part of life, however when it occurs in an inappropriate context it can be detrimental to those involved or witnessing the behaviour. The physical and psychological safety of the client is paramount.

NSW Health has developed an example of sexual safety standards of behaviour which may be helpful for services developing their own standards for acute and extended treatment inpatient services. Refer to Appendix A.

11.1 Considerations for clients under 18

Distinguishing inappropriate from normal sexual behaviour in children and young people may be difficult. The use of evidence based tools like the *Traffic lights: guide to sexual behaviours in children and young people* assists parents and carers, teachers and health professionals in recognising and responding to sexual behaviour in young children (True - relationships and reproductive health, 2015).

Staff should also be guided by information contained in the Queensland Health Guideline for Reporting a Reasonable/Reportable Suspicion of Child Abuse and Neglect, Section 8 Sexual activity in a young person, which outlines issues staff should consider when assessing the appropriateness of sexual activity in young people, such as a significant age gap or an inappropriate power differential.

11.2 Considerations for clients in extended treatment or community care units

People accessing extended treatment or residential rehabilitation units may reside in these facilities for months or years. Establishing a safe recovery-oriented environment includes establishing a culture that is pro-social and promotes sexual safety. Staff should educate clients to provide them with skills in negotiating interpersonal relationships, including intimate relationships, as part of their mental health rehabilitation.

Policies on interactions with visitors to these facilities should be clearly explained upon admission. Treatment contracts may be useful in these situations as clients are attending for rehabilitation and may be more able to understand and engage in interventions such as treatment contracts. In developing policies regarding sexual relationships between clients in an extended treatment inpatient setting, staff should be guided by the following:

- Policies regarding sexual relationships in extended treatment inpatient services (other than acute inpatient services) should be developed following assessment of the service environment, consideration of responsibilities of the Service to clients, and the individual circumstances and issues for each client.

- Intimate and sexual relationships between clients in extended treatment services require careful examination in the context of informed consent, impaired judgement and vulnerability.
- Information obtained during the mental health assessment and risk assessment should be considered when applying policies about intimate and sexual relationships between individual clients.
- Clients involved should be consulted regarding any decision making processes, provided with all relevant information regarding their rights and choices, and be given the opportunity to contribute to the decision making process.
- Clients should have access to information regarding safety, contraception, sexually transmissible infections, referral and support options to access further advice and information.

12. Vulnerable groups

It is important to be aware of issues of diversity, including culture, language, disability, religion, sexuality, gender identity, geographic location and how these differences can increase clients' vulnerability. Services should provide access to appropriate care to respond to the diverse needs of all clients.

Geographic context

Some geographical locations may experience known outbreaks or higher incidence of specific illnesses including sexually transmitted infections (STIs). Clinicians may need to consider this as part of their assessment of the client's vulnerabilities, in treatment plans and links to other service providers.

Aboriginal and Torres Strait Islander people

Generally, Aboriginal and Torres Strait Islander people do not openly discuss matters relating to sex or sexual behaviours, practices, identity, preferences and interests, therefore seeking advice and treatment for issues relating to sexual health is difficult. Disclosing or discussing sexual health matters may be viewed as breaching cultural practices and can evoke feelings of 'shame' or internal disharmony. The gender of the staff caring for the Aboriginal and Torres Strait Islander consumer is vital, as in some communities it is considered taboo for men and women to discuss sexual behaviour with each other (Queensland Health, 2013).

For additional information regarding promoting, improving and maintaining the mental health of Aboriginal and Torres Strait Islander people, staff should refer to their Hospital and Health Service Indigenous Mental Health Worker or Indigenous Health Worker.

People from culturally and linguistically diverse backgrounds

Culturally responsive practice recognises that culturally and linguistically diverse clients may have specific cultural needs or preferences, including cultural, religious and language needs. Where English is identified as a second language, accredited interpreters and culturally appropriate support persons should be used, precluding children, relatives and friends, to provide the client with information which enables them to make informed decisions about health care, forensic and legal processes. Clients should be advised of their right to access interpreters and if requested, interpreters should be provided for all stages of care.

When working with clients from diverse cultural and linguistic backgrounds, consideration must be given to the fact that many migrants and refugees may have experienced violence as part of their pre or post migration history, which may include sexual violence.

Additionally, they may have past experiences impacting on their ability to trust systems or services affecting their interaction with medical staff. Past experiences of trauma have the potential to hinder the relationship with services providing support, if those experiences have not been disclosed to or understood by the service provider.

People who are deaf or hearing impaired (sometimes referred to as hard of hearing)

Significant issues and access barriers exist for clients who are deaf or hearing impaired. Culturally Deaf who use Auslan are a particularly vulnerable group as they do not share the dominant language of the population. Sexual assault can go unreported and unrecognised. The deaf and hearing impaired population is diverse, including clients who are late deafened, deaf-blind and may be from non-English speaking backgrounds. A culturally sensitive response should be provided, considering environment and need for interpreters.

People with a disability

People with a disability which results in impairment of cognitive function or communication ability, may experience a substantial reduction in their capacity to communicate or make informed decisions. Where the client has a disability, Services must facilitate access to appropriate support workers and/or interpreters.

People who identify as lesbian, gay, bisexual, transgender and/or intersex

People who identify as lesbian, gay, bisexual, transgender and/or intersex (LGBTI) and men who have sex with men (MSM) have specific needs. LGBTI and MSM populations may face particular barriers to access and discrimination in accessing appropriate services. Service responses may not take into account the specific needs of these groups, impacting upon the appropriateness of care and their experience of the health system. As in the case of all people from diverse backgrounds or minority groups, LGBTI and MSM clients have the right to receive services and support free from discrimination and judgement. Services must facilitate access to appropriate support workers and service options where the client identifies as being LGBTI or MSM.

Evidence suggests LGBTI and MSM individuals experience poorer mental health, higher rates of substance abuse, social isolation and exclusion and subsequently poorer health outcomes. It is also important to be aware that transgender and intersex persons may have a sexual orientation that increases their risk of sexual health and/or related mental health issues (Queensland Health, 2016).

People experiencing gender dysphoria

Gender dysphoria is a condition of feeling one's emotional and psychological identity as male or female to be opposite to their biological sex. Children and young people with gender dysphoria often experience distress, with over 47% of children and 85% of adolescents reporting behavioural or mental health problems (Queensland Health, 2016).

Children and young people under the age of 18 years

Children and young people will display sexual behaviours on a continuum - ranging from healthy and age appropriate to unhealthy and problematic. Therefore age specific services for children and young people should not be automatically assumed free from risks to sexual safety. A robust system of risk assessment and management strategies, suitable for this cohort, needs to be maintained to

ensure sexual safety. The decision making capacity of young people under the age of 18 years may require additional consideration and consultation with the multidisciplinary treating team.

Older people

Societal attitudes traditionally under recognise the continuing place of sexuality and sexual behaviour in the lives of older people. These perceptions can lead to staff responses to sexual behaviour which reflect a lack of awareness and identification of risk issues and appropriate responses to sexual health considerations and sexual safety incidents in this population group (W Norton, 2015).

Factors which should be taken into consideration when formulating care plans addressing sexual safety for older clients in the mental health setting include the presence of cognitive impairment; BPSD (dementia complicated by behavioural and psychological symptoms such as inappropriate sexual behaviour, intrusiveness and wandering); physical frailty; mobility issues and sensory and communication deficits (hearing, sight and speech). This list is not exhaustive.

Services need to ensure the inclusion of older adults in local sexual safety policies and procedures. These policies should prompt sensitive and specialised responses to sexual safety incidents in this group.

13. Sexual relationships between staff and clients

At no time is it acceptable for a clinician, consumer consultant, peer worker or volunteer working in a Service to engage in a sexual relationship with a client. This is the case regardless of the position they hold, irrespective of whether the relationship was initiated by the client or not, and whether it may be considered 'consensual' or not.

The behaviour of all employees of Queensland Health should adhere to the Queensland Public Service Code of Conduct 2011 and the National Code of Conduct for Healthcare Professionals (Queensland) 2015.

If a client or a client's family member and/or support person alleges that an employee has engaged in sexual behaviour with a client, appropriate action must be taken. Staff should:

- advise the client of their obligation to follow up on the matter and provide appropriate support to the client
- report the matter to the relevant line manager immediately
- maintain confidentiality about the incident outside of the reporting obligations (Metro North Hospital and Health Service, 2015)
- accurately document all information provided, the action taken; and complete an incident report as soon as is practical.

The line manager must immediately refer the matter to the clinical director for action.

The Office of the Health Ombudsman (OHO) receives all complaints in Queensland about health services and health service providers, including registered and unregistered health practitioners. The OHO manages complaints about any aspect of health service including inappropriate behaviour by a clinician. The Australian Health Practitioner Regulation Agency (AHPRA) outlines professional codes of conduct for a range of health disciplines.

The Service should adhere to the OHO Guidelines on mandatory notifications for guidance pertaining to notification of sexual misconduct by a health service provider. A registered practitioner

breaching their professional code of conduct may be restricted from practice by the OHO or AHPRA whilst an investigation is being undertaken. If the practitioner is found to be in breach of their professional code and/or having engaged in criminal behaviour, they may have their registration restricted or revoked temporarily or on a permanent basis. Further information on registering a health complaint is available on the OHO website at: <http://www.oho.qld.gov.au/> and professional code of conduct for health professionals is available on the AHPRA website at: <https://www.ahpra.gov.au/>.

14. Privacy, confidentiality, documentation and record keeping

As well as documenting sexual safety incidents in clinical incident reporting systems and the client health record, staff should consider utilising alerts in CIMHA to share essential information about a client and ensure safe, appropriate and timely responses to sexual safety issues. CIMHA alerts which may augment sexual safety risk mitigation include inappropriate sexual behaviour, cultural needs and disability.

Queensland Health has a longstanding commitment to ensuring the privacy and confidentiality of personal information collected. Queensland Health is subject to privacy and confidentiality legislation which set the standards for how staff handle personal information.

The two primary pieces of legislation are the *Information Privacy Act 2009* (IP Act) and Part 7 of the *Hospital and Health Boards Act 2011* (HHB Act). The term 'Personal information' is defined in the IP Act and can be any information or opinion about an identifiable living individual; including staff, patients and the community more broadly. The term 'Confidential information' is defined in the HHB Act and means information, acquired by a person in the person's capacity as a designated person, from which a person who is receiving or has received a public sector health service could be identified.

Patient confidentiality in Queensland public sector health services is strictly regulated. Under Part 7 Section 142 of the HHB Act there is a duty of confidentiality imposed on Queensland Health staff in relation to the protection of confidential information. However, there are also circumstances where it is necessary to share or release confidential information. This is recognised in Part 7 through the inclusion of provisions which allow for the disclosure of confidential information. It is an offence to disclose confidential information about a person unless one of the exceptions in Part 7 applies.

Everyone who accesses public sector health services has a right to expect that information held about them will remain private. Collecting information from clients should be in accordance with the IP Act which includes the Australian Privacy Principles. These principles address the collection of personal information like people's health and sexual orientation or practices.

When responding to an allegation of sexual assault and documenting the incident, staff should be guided by the following:

- Collect only the information that is necessary for the Service's functions or activities. Collect personal information from the client directly wherever possible, and take steps to notify a client about what information you are collecting, why (including whether you have a lawful requirement to collect it) and what you intend to do with the information.
- Access to, and disclosure of, personal information regarding the sexual assault should be limited to people directly involved in the case, unless the disclosure is required or permitted by law.

- Documentation about the incident in a client's health record should adhere to legislative and policy requirements.
- Clinical records, both paper-based and electronic, should be protected by appropriate security safeguards to prevent unauthorised access, use, modification, disclosure, loss or destruction.
- All reports regarding a sexual assault incident should be maintained in a confidential manner and stored in an appropriately secure area.
- Client records may be disclosed to another staff member for the purposes of evaluating, managing, monitoring or planning health services
- Clients should be advised that in some instances there may be a legal duty to produce documents. Comprehensive documentation and maintenance of accurate records is imperative to ensure an appropriate response, effective management and service accountability.
- Where confidential information is disclosed it is important that only information that is relevant to the particular circumstances be disclosed (i.e. the minimum necessary to satisfy the particular requirement).

For further information in regard to privacy and confidentiality please refer to the Privacy and Confidentiality Contact Officer within your Hospital and Health Service and the Australian Charter of Healthcare Rights.

15. Service evaluation/monitoring of practice

Regular Service evaluation is critical for facilitating a contemporary, effective and best practice service delivery model. Services should be guided by the following principles:

- regularly monitor and evaluate service delivery and Service response against locally developed policies, strategic plans, and performance indicators
- provide clients, family members and staff with the opportunity to contribute to reviews and evaluations
- regularly evaluate and review local interagency links and partnerships to assist in an integrated response
- provide opportunities and mechanisms for external services to provide feedback and evaluation of Service delivery and collaboration with external services.

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Approval and implementation

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1	30/08/2016	Clinical Governance Team	First publication
1.1	27/03/2017	Clinical Governance Team	Minor clarifications made to sections 8.4, 10, and 12.

Appendix A

Example Sexual Safety Standards of Behaviour (New South Wales Ministry of Health, 2013)

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 else 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 else 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.
