



Improving sexual safety in mental health and wellbeing services

Chief Psychiatrist's guideline – September 2023

OFFICIAL

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In this document, 'Aboriginal' refers to both Aboriginal and Torres Strait Islander people. 'Indigenous' or 'Koori/Koorie' is retained when part of the title of a report, program or quotation.

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Purpose

This Chief Psychiatrist's guideline sets out the relevant legislation and policy and establishes minimum standards for:

- promoting sexual safety
- supporting human rights
- assessing and managing risks
- identifying and responding to incidents
- reporting sexual safety incidents.

This guideline provides principles and minimum standards for governance requirements, prevention strategies and responses to sexual safety incidents. It also suggests follow-up actions to assist mental health service managers, clinical directors, lived experience workers, clinical staff and other support staff in their obligations to promote a safe, therapeutic culture and environment. Services should develop local policies based on the guideline to promote awareness of sexual safety.

This document includes links to other relevant information or clinical advice. Refer to the [References and resources](#) section for a full list of other resources.

This guideline has been developed through extensive consultation with people with lived experience of using mental health and wellbeing services, their families, carers and supporters, mental health clinicians and other stakeholders. It has also been informed by a substantial review of the literature.

The information in this guideline is divided into two sections:

Part 1: Practice guidance for risk assessment and management, identifying and responding to incidents, documenting, and reporting incidents and patient transfer

Part 2: Principles of care for sexual safety.

Key messages

Focus

- Everyone in mental health and wellbeing services (including consumers, staff and visitors) has a right to sexual safety. Services have a responsibility to prevent sexual safety incidents from occurring and a duty of care to provide bed-based care settings that are safe.
- The Royal Commission into Victoria's Mental Health System noted that all clinical mental health service providers must meet the minimum standards for sexual safety set out in the Chief Psychiatrist's guideline.
- In all bed-based services in community, custodial and in hospital settings **any alleged, witnessed or suspected occurrence of sexual harassment or sexual assault, and in most cases sexual activity, constitutes a sexual safety incident**. Respond to these incidents in line with this guideline and report appropriately.
- All mental health and wellbeing services should develop local policies, procedures and governance structures in consultation with consumers, families, carers and supporters that support sexual safety and are consistent with this guideline.

Approach

- Services must promote and respond to sexual safety incidents with practice that is trauma-informed, family-inclusive, least restrictive, recovery-oriented and culturally safe. Responses must follow human rights and supported decision-making principles.
- Approaches to sexual safety must be free from judgement and promote respect, trust, choice, empowerment and collaboration within the therapeutic relationship.

Reporting

- Make a sexual safety notification to the Chief Psychiatrist following any sexual safety incident in bed-based clinical mental health services as per the [Chief Psychiatrist's reporting directive: Sexual safety incidents](https://www.health.vic.gov.au/chief-psychiatrist/improving-sexual-safety) < <https://www.health.vic.gov.au/chief-psychiatrist/improving-sexual-safety>
- Sexual safety incidents are likely be reportable to police. In some instances, reporting to the police is mandatory – refer to section [5.1 Reporting to police](#)).

Population groups

- Services are to be inclusive and safe for population groups that experience different forms of disadvantage or marginalisation, recognising the unique barriers and experiences of safety for particular groups. These groups include LGBTIQ+ people, culturally diverse communities and Aboriginal Victorians.
- Services must offer support that meets the needs of all consumers across the lifespan and to include families, carers and supporters where appropriate.

Scope

The advice in this guideline is relevant to all mental health and wellbeing services in Victoria. Clinical mental health service providers, including designated mental health services and mental health and wellbeing services in custodial settings, must follow the directions outlined in this guideline. Bed-based services delivered by clinical mental health service providers must report sexual safety incidents to the Office of the Chief Psychiatrist. This includes services that clinical mental health service providers deliver under public private partnerships.

Services in scope should review their own procedures and clinical practices to ensure they align with this guideline. This guideline applies to all consumers across the lifespan and needs to include the person's appointed representative or family, carers and supporters (as appropriate).

Language

For more information refer to:

- [NSW Mental Health Co-ordinating Council's Recovery oriented language guide](http://www.mhcc.org.au/wp-content/uploads/2019/08/Recovery-Oriented-Language-Guide_2019ed_v1_20190809-Web.pdf) <http://www.mhcc.org.au/wp-content/uploads/2019/08/Recovery-Oriented-Language-Guide_2019ed_v1_20190809-Web.pdf>
- [Safewards handbook](https://www.health.vic.gov.au/practice-and-service-quality/safewards-training-resources) <<https://www.health.vic.gov.au/practice-and-service-quality/safewards-training-resources>>
- [LGBTIQ inclusive language guide](https://www.vic.gov.au/inclusive-language-guide) <<https://www.vic.gov.au/inclusive-language-guide>>.

Definitions

Aboriginal – In this document, 'Aboriginal' refers to both Aboriginal and Torres Strait Islander people.

Advance statement of preferences A document that sets out a person's preferences in relation to their treatment, care and support if the person becomes a patient under the Act (s 57).

Alleged instigator – A person who is alleged to have physically, psychologically or emotionally harmed another resulting from a sexual safety incident. This term is used when the person is a consumer to reflect the potential vulnerability of all consumers in bed-based services.

Alleged perpetrator – A person who is alleged to have physically, psychologically or emotionally harmed another resulting from a sexual safety incident. This term is used when the person is not a consumer (a staff member, visitor or other), which aligns with language used in other sectors.

Authorised psychiatrist A psychiatrist appointed by a designated mental health service under s 328 of the Act to carry out the functions and exercise the powers conferred on an authorised psychiatrist under the Act or any other Act and support the chief psychiatrist to perform the chief psychiatrist's functions under the Act. An authorised psychiatrist can delegate a function or power to certain individuals under s 329 of the Act.

Carer - A person, including a person under the age of 18 years, who provides care to another person with whom they are in a care relationship (per s 3 of the Carers Recognition Act 2012), but does not include a parent if the person to whom care is provided is under the age of 16 years (s 3(1)).

Clinical mental health service provider A designated mental health service or a mental health and wellbeing service provided in a custodial setting.

Consumer A person who has or is receiving mental health and wellbeing services or was assessed by an authorised psychiatrist and is not receiving treatment or sought or is seeking mental health and wellbeing services and was not or is not provided with those services.

Consent (sexual) – In Victoria, both parties must freely and voluntarily agree to the sexual act for the act to be consensual. Consent means 'free and voluntary agreement' under section 36 of the *Crimes Act 1958* (the **Crimes Act**). Section 36 includes what does and does not constitute consent. *Note that consumers in inpatient units may or may not have the capacity to consent to sexual activity, and this capacity will fluctuate over time.*

Consumer – a person who is receiving mental health and wellbeing services from a mental health and wellbeing service provider' (s 3(1)(b))

Designated mental health service A prescribed public hospital, prescribed public health service, prescribed denominational hospital, prescribed privately-operated hospital, prescribed private hospital that is registered as a health service establishment under the Act, the Victorian Institute of Forensic Mental Health, a service temporarily declared to be a designated mental health service or a declared operator (per s 3(1) of the Act).

Families Carers and Supporters refers to the network of people that support consumers with their mental health and wellbeing. **Family** refers to family of origin or family of choice". Throughout this document, practice that is inclusive of family, carers and supporters is promoted. This inclusion must always be with the consent of the consumer or aligned to the information sharing principles of the Act.

LGBTIQ+ definitions – For comprehensive definitions refer to the *LGBTIQ inclusive language guide* <<https://www.vic.gov.au/inclusive-language-guide>>. A **cisgender** person is someone whose gender aligns with the sex they were assigned at birth. A **transgender** person is someone whose gender does not exclusively align with the one they were assigned at birth.

Mental health intensive care – This is a specialist care type providing support, safety and therapeutic engagement for people experiencing increased risk or vulnerability associated with an acute mental illness.

Mental health intensive care area – A discrete space (that may be locked) within an acute inpatient unit that provides mental health intensive care. They are sometimes referred to as high dependency units (HDUs).

Mental health and wellbeing service refers to a service performed for the primary purpose of improving or supporting a person's mental health and wellbeing, assessing or providing treatment, care or support to a person for mental illness or psychological distress or providing care or support to a family member, carer or supporter of a person with mental illness or psychological distress

Sexual activity – An activity may be sexual due to (a) the area of the body that is involved in the activity, including (but not limited to) the genital or anal region, the buttocks or the breasts; or (b) the fact that the person engaging in the activity seeks or gets sexual arousal or sexual gratification from the activity; or (c) any other aspect of the activity, including the circumstances in which it is engaged in (Crimes Act, s 35D). Sexual activity may be consensual or non-consensual (refer to the Crimes Act). Consensual sexual activity is not a crime (unless the person is not of the legal age to consent). Non-consensual sexual activity is a crime.

Sexual assault – Under the definition of sexual assault in section 40(1) of the Crimes Act, a person (person A) commits an offence if: person A intentionally touches another person (B); and the touching is sexual; and B does not consent to the touching; and A does not reasonably believe that B consents to the touching.

Sexual assault may also include behaviour that does not include actual touching such as forcing somebody to watch pornography or masturbation. Specific provisions relating to sexual offences against persons with a mental illness are detailed in Subdivision 8E of the Crimes Act.

Sexual disinhibition – Poorly controlled behaviour of a sexual nature where sexual thoughts, impulses or desires are expressed in a direct or disinhibited way, such as in inappropriate situations, at the wrong time or with the wrong person. Sexual disinhibition is a feature of some mental illnesses. Consider this when collaboratively planning a person's treatment, care and support.

Sexual harassment – Unwelcome sexual behaviour that causes a person to feel offended, humiliated or intimidated, where a reasonable person could have anticipated that reaction in the circumstances. It includes an unwelcome sexual advance, an unwelcome request for sexual favours, and any other unwelcome conduct of a sexual nature. It can be physical, verbal or written (*Equal Opportunity Act 2010* (Vic) (the **EO Act**)). In some, but not all, circumstances sexual harassment is against the law.

Sexual health – A state of physical, emotional, mental and social wellbeing related to sexuality, not merely the absence of disease, dysfunction or infirmity.

Touching and sexual touching – The Crimes Act (s 35B (1)) defines 'touching' – touching may be done (a) with any part of the body; or (b) with anything else; or (c) through anything, including anything worn by the person doing the touching or by the person touched. Under section 35B (2). touching may be sexual due to (a) the area of the body that is touched or used in the touching, including (but not limited to) the genital or anal region, the buttocks or, in the case of a female or a person who identifies as a female, the breasts; or (b) the fact that the person doing the touching seeks or gets sexual arousal or sexual gratification from the touching; or (c) any other aspect of the touching, including the circumstances in which it is done. Non-sexual touching is not prohibited by the Crimes Act. Examples of non-sexual touching may be a hug or holding hands.

Women-only/gender-sensitive areas – Dedicated spaces for use by people, in line with their wishes, who identify as a cisgender or transgender woman or girl, a transgender man or a non-binary person.

Introduction

Sexual safety in mental health and wellbeing services is a priority for Victoria's Chief Psychiatrist, who has a statutory obligation to provide clinical leadership and guidance to promote continuous quality and safety improvement and promote human rights (the Chief Psychiatrist's role is detailed in section 266 of the *Mental Health and Wellbeing Act 2022* (the Act)).

Reporting sexual safety incidents to the Chief Psychiatrist is a key part of this work. The collection and analysis of this information offers the opportunity to review substantial sexual safety breaches and provides a detailed picture of sexual safety issues across the system. This information can be used to inform better approaches to ensuring sexual safety across mental health and wellbeing services.

All consumers, staff and visitors have a right to be and feel sexually safe in Victoria's mental health and wellbeing services. Service providers have a responsibility to proactively prevent sexual safety incidents and respond appropriately when sexual safety incidents occur.

The final report of the Royal Commission into Victoria's Mental Health System (2021) noted the need for immediate action to address gender-based violence in mental health and wellbeing services. Recommendation 13 outlined significant reform including ensuring each facility meets the minimum standards for sexual safety set out in the Chief Psychiatrist's guideline. The Royal Commission also called for a new approach to addressing trauma including capacity building in services to respond appropriately to trauma. A trauma-informed approach is integral to supporting sexual safety. Engagement with new approaches and resources for this approach need to be considered when implementing this guideline.

Principles for practice

The mental health and wellbeing principles, and the decision-making principles outlined in the Act (Parts 3.1 & 1.5) must guide practice for preventing and responding to sexual safety in mental health and wellbeing services.

Mental health and wellbeing principles

The Act sets out 13 mental health and wellbeing principles and service providers must make all reasonable efforts to adhere to these principles (Part 1.5). All 13 principles must be used to guide sexual safety practice, especially to uphold the dignity and autonomy of consumers, to provide care in the least restrictive way possible, to practice supported decision making, and ensure the safety and wellbeing of young people. The gender safety principle is also critical to delivering sexually safe mental health and wellbeing services. This principle identifies that consumers may have specific safety needs relating to their gender and that services must be safe, sensitive to the way gender may affect service delivery, and responsive to family violence and trauma.

Decision making principles for treatment and interventions

The Act sets out 5 decision making principles for treatment and interventions and mental health and wellbeing service providers have a statutory responsibility to give these principles proper consideration when making decisions about treatment or the use of restrictive interventions. This consideration must be documented and reviewed according to changing needs. All decision-making principles can be applied to sexual safety. Particular attention should be given to the autonomy principle which requires that the preferences of a person are to be given effect to the greatest extent

possible in all decision making. This is especially relevant to consumers who have experienced a sexual safety incident or have experienced other trauma. Refer to the [Chief Psychiatrist's interim guideline on Decision making principles for treatment and interventions](https://www.health.vic.gov.au/chief-psychiatrist/decision-making-principles-for-treatment-and-interventions-mental-health-and-wellbeing-act-2022)
<<https://www.health.vic.gov.au/chief-psychiatrist/decision-making-principles-for-treatment-and-interventions-mental-health-and-wellbeing-act-2022>>

Information sharing principles

Part 17.1 of the Act contains information sharing principles which mental health and wellbeing service providers must consider when deciding to disclose, use or collect health or personal information. These principles must be used to guide practice when sharing information regarding sexual safety, for example following a sexual safety incident.

Part 1: Practice guidance for risk assessment and management, identifying and responding to incidents, documenting, and reporting incidents and patient transfer

1. What is sexual safety?

All consumers, staff and visitors have the right to be and feel safe in mental health and wellbeing services. To achieve this, mental health and wellbeing services must ensure an environment that is free from sexual harm including sexual harassment and sexual assault, and sexual activity in cases where such activity has the potential to cause harm.

All services have a duty of care to ensure sexual safety. To support this, services must have clear processes to promote sexual safety and to respond appropriately to any sexual safety incidents that occur.

1.1 What is a sexual safety incident in different settings?

Sexual safety incidents may consist of any alleged, suspected or witnessed occurrence of sexual activity, sexual harassment or sexual assault. Report these to the Office of the Chief Psychiatrist.

Specific information on reporting requirements to the Chief Psychiatrist can be found in the [Chief Psychiatrist's reporting directive: reporting sexual safety incidents to the chief psychiatrist](https://www.health.vic.gov.au/chief-psychiatrist/improving-sexual-safety)
<<https://www.health.vic.gov.au/chief-psychiatrist/improving-sexual-safety>>

1.1.1 Sexual safety incidents in bed-based clinical mental health services

Any witnessed, suspected or alleged occurrence of **sexual harassment** or **sexual assault** constitutes a sexual safety incident in all bed-based clinical mental health services.

Any witnessed, suspected or alleged occurrence of **sexual activity** also constitutes a sexual safety incident in bed-based services in hospital settings (for example, acute inpatient services and secure extended care units (SECUs) and mother baby units), in all bed-based services for people aged under 18 years, and in all prevention and recovery care (PARC) services.

Non-acute bed-based services that provide a longer term, home-like environment (for example, community care units (CCUs)) can develop local protocols around whether sexual activity is considered a sexual safety incident. Services that permit sexual activity develop local protocols to support consumers who wish to engage in sexual activity to do so safely. Services have a responsibility to ensure support around sex and sexuality is accessible as a part of recovery-oriented practice. Services in this category that do not think that consumers can be supported to engage in sexual activity safely in their environment should prohibit sexual activity. **In services where sexual activity is prohibited, treat it as a sexual safety incident** and respond in line with this guideline.

1.1.2 Sexual activity when a consumer is on leave

Consumers have a right to express their sexuality in appropriate settings. Consumers may engage in sexual activity when on leave. Where a consumer expresses an intent to engage in sexual activity while on leave, the service must collaborate with the consumer in weighing up the degree of risk, respecting the consumer's rights, dignity and autonomy. Supported decision making including a discussion about sexual health and contraception/condoms (including how and where to obtain contraception/condoms) and whether the consumer feels they can safely engage in sexual activity (or whether psychological or physical harm may result) may be important. For supporting information refer to the [Chief Psychiatrist's guideline: inpatient leave of absence](https://www.health.vic.gov.au/chief-psychiatrist-guidelines/inpatient-leave-of-absence) <<https://www.health.vic.gov.au/chief-psychiatrist-guidelines/inpatient-leave-of-absence>>.

If a consumer engages in sexual activity while on leave and details are provided to staff, the service may treat this as a sexual safety incident as a precautionary measure and report the incident to the Office of the Chief Psychiatrist. Staff should use their discretion and clinical judgement following discussion with the clinical team and consumer and, where appropriate, families, carers and supporters.

2. Prohibited sexual activity

Sexual activity, even when it seems consensual, is not appropriate in nearly all bed-based mental health service settings and is prohibited. (Refer to section [1.1. What is a sexual safety incident in different settings](#) for details of service settings where sexual activity may be permitted in some instances.) Staff need to respond to all sexual safety incidents without making judgements about whether they believe the activity was consensual.

Bed-based services must provide a treatment environment that feels safe for all consumers. In some environments, particularly when the level of acuity is high or there is rapid turnover of consumers, it is not possible to ensure that sexual activity does not cause harm for those who are involved or those who may witness it. Other factors to consider include:

- When admitted to bed-based clinical mental health services, particularly in acute settings, some consumers may lack the capacity to consent to sexual activity.
- Symptoms such as sexual disinhibition or impaired judgement have a substantial impact on people's sexual behaviour.
- Sedation from medication, disorganised thinking or other symptoms may make consumers particularly vulnerable to being sexually exploited.
- People with a history of sexual assault or other trauma can be vulnerable to sexual exploitation.
- Power imbalances (due to gender or authority) and predatory behaviour can also be present within bed-based clinical mental health services, making it difficult to establish if sexual activity is genuinely consensual.
- Some consumers may have the capacity to consent to sexual activity, but they may unwittingly commit sexual assault by engaging in sexual activity with a person who does not have the same decision-making capacity.
- People may feel unsafe if they hear, see or are otherwise aware of sexual activity occurring within the service, especially people with a history of sexual assault or trauma.
- Bed-based clinical mental health services are workplaces covered by occupational health and safety legislation. They are also considered public spaces where certain behaviours are unacceptable.

Sensitivity and empathy are required when prohibiting sexual activity. Staff must promote respect, trust, dignity, choice, and empowerment that is free from judgement when responding to sexual activity. They should consider the following factors:

- Sexuality is fundamental to the human condition, and consumers have the same desire for intimate relationships and sexual expression as everyone else.
- The right to a private life is a human right that includes the right to sexual expression between consenting adults.¹
- Bed-based clinical mental health services are a place where social interaction, not just treatment, occurs. Many consumers in bed-based services may not have chosen to be there and this may affect how they interact socially in these environments.
- Consumers may seek relationships and intimacy to help their recovery.
- It cannot be assumed that consumers do not have capacity to consent to sexual activity. Capacity can vary over time.
- Therapeutic touch can be an important element of recovery.

2.1 Limited exceptions

There are forms of physical touching or sexual expression that occur during admission that are not considered harmful and are not in most instances considered sexual safety incidents.

- Private masturbation where other consumers or staff cannot witness it should not be considered a sexual safety incident, staff must be conscious of giving consumers privacy.
- Non-sexual touching may not be considered a sexual safety incident. Examples of non-sexual touching may be a hug, handholding, a kiss on the cheek or a pat on the shoulder. These behaviours can, however, also be experienced as sexual harassment regardless of the intent. If observed, staff should speak individually with the consumers involved to check whether they are comfortable with this kind of touching. If not, staff should work with the affected consumer(s) to put supportive safety measures in place. Checking directly with affected consumers offers an opportunity to intervene early to promote safety and prevent adverse incidents.

3. Assessing individual risks and needs

Include assessing sexual safety risks and planning for sexual safety in a consumer's broader risk assessment. The aim is to identify consumers who may be at risk of sexual assault or exploitation, and consumers who may behave in a way that is sexually inappropriate or assaultive. Consider the following factors:

- personal characteristics such as gender, LGBTIQ+ identity, cultural background, disability status
- symptoms that may increase risk such as hypomania, mania, sexual disinhibition, disorientation or confusion
- a known or suspected history of experiencing violence including sexual violence or family violence
- a history of perpetrating interpersonal violence, sexual offending or assaultive behaviour
- a history of sexually inappropriate behaviour

¹ Article 8 of the European Convention on Human Rights.

- sedation caused by medication
- substance use or dependence
- subtle means of coercion, grooming or manipulation, not only overtly violent (physical or sexual) behaviour
- age-inappropriate sexual behaviour (for example, overtly sexual behaviour in children).

3.1 Responding to sexual disinhibition

Sexual disinhibition is often a symptom of mental illness. Responding to sexual disinhibition and associated behaviours is part of treatment, care and support, and is a crucial prevention strategy. Vigilance and constant awareness of disinhibition, and the potential for sexual safety incidents as a result, are key.

Disinhibition may present as an increase in sexual thoughts, activities or demeanour. When a consumer is displaying disinhibited behaviours, take immediate measures to protect them and others to ensure sexual safety. Measures include:

- Review the consumer's risk assessment and safety plan – practice can be guided by strategies that have been useful for a particular consumer in the past.
- Increase staff presence and provide care to help maintain boundaries.
- Ensure the consumer is always adequately clothed or given privacy.
- Counsel consumers about their behaviour and remaining sexually safe without being judgemental or punitive.
- Maintain clinical vigilance to identify and prevent uncharacteristic behaviours.
- Seek advice from families, carers and supporters about how to respond to the consumer.
- Use [Safewards](https://www.health.vic.gov.au/practice-and-service-quality/safewards-training-resources) <<https://www.health.vic.gov.au/practice-and-service-quality/safewards-training-resources>> 'calm down methods' (for example, sensory modulation) and/or 'talk down' intervention to help de-escalate and defuse sexually disinhibited behaviours.

4. Identifying and responding to sexual safety incidents

Respond to all sexual safety incidents in line with this guideline. The principles of human rights, trauma-informed care, supported decision making and the least restrictive approach must inform all decision making. All staff must practise in a family-inclusive, recovery-oriented and culturally safe way when responding to incidents. For clarity about what constitutes a sexual safety incident refer to section [1.1 What is a sexual safety incident in different service settings?](#).

For prompts to guide responses to sexual safety incidents refer to Appendices 1 and 2.

4.1 Identifying sexual safety incidents

Ensure staff are accessible and open to hearing from consumers, families, carers, and supporters or advocates about sexual safety incidents. Staff must also be alert to changes in a consumer's presentation that may indicate an incident having occurred.

4.1.1 Identifying incidents

Incidents may be identified through:

- disclosures, either direct from consumers to staff or relayed by families, carers and supporters, or advocates
- a third-party observer's report or disclosure (for example, other consumers or visitors)
- observing significant changes in the consumer's behaviour or presentation (for example, distress, withdrawal, anger, sleep disturbance, changes to eating behaviour, suicidality or depression, self-harm, panic attacks)
- the consumer reporting physical symptoms.

4.1.2 Barriers to disclosing incidents

Barriers to disclosing incidents can include:

- fear that this will be seen as a symptom of illness, and reporting the incident will lead to more assertive/restrictive treatment
- the psychological effect of the sexual safety incident – the impact of trauma and fear of the alleged instigator or perpetrator
- concerns about privacy and confidentiality (for example, fear of staff telling police or others the consumer would not want to know such as a parent)
- lack of confidence that the incident will be taken seriously and responded to appropriately
- negative past experiences with mental health and wellbeing services
- past or anticipated negative experiences with police and courts
- for LGBTIQ+ people, reluctance to reveal the sexuality or gender identity
- consumers feeling they may be judged or that they may not be heard, understood or believed.

4.2 Responding to sexual safety incidents

At every stage of responding to sexual safety incidents staff should be informed by section 2 in Part 2: Principles of care.

4.2.1 Providing care after a sexual safety incident

Establishing safety

After a sexual safety incident, the priority is to re-establish a safe therapeutic environment for everyone. This means considering the physical, psychological and emotional safety of all consumers, staff and visitors. Ensure the people who have been affected by the incident are supported to move to a safe environment in line with their preferences and have access to immediate support. This should occur in discussion with the affected person; avoid moving them to a more restrictive environment against their wishes. Moving consumers to a different environment must not be used as a punitive response. Assess and respond to immediate and ongoing risks following an incident. Review and enact risk assessments and safety plans.

Psychological support/validation

Following a sexual safety incident, it is crucially important that the interpersonal response to consumers is sensitive, supportive and trauma-informed (refer to Appendices 1 & 2). Responses

that are punitive, judgemental, disbelieving or uncompassionate can cause further harm and intensify post-trauma responses.

- Take consumers to a quiet safe place where they can discuss what happened.
- Give consumers the option to share information in whatever way is most comfortable for them, for example, being given the option to write things down.
- Give consumers as much choice as possible around how they are supported including which staff support them, how they share their story (for example, being given the option to write things rather than verbally discuss) and what actions are taken. Consider the consumer's preference of staff member about their role (for example, peer support, allied health), skill set, gender and so on.
- Take the time to hear the consumer's story, and let the consumer know they are believed.
- Consider and ask if the consumer would like a particular family member or friend to come in and offer immediate support alongside staff.
- Avoid asking the consumer to retell their story multiple times to different staff.
- Always offer this level of support to consumers who report a sexual safety incident. This includes when the clinical assessment is that the event was unlikely to have occurred.

Referral to specialist services

Following a sexual safety incident consumers can contact a local Centre Against Sexual Assault (CASA) during business hours or the Sexual Assault Crisis Line (SACL) after hours for support, advice and secondary consultation:

- [CASA](https://www.casa.org.au/contact-us/) <https://www.casa.org.au/contact-us/> (statewide)
- [SACL](https://www.sacl.com.au/) <https://www.sacl.com.au/> – phone 1800 806 292

Offer consumers the opportunity to engage with one of these services immediately after an incident, with staff clearly outlining the benefits of this referral. CASA/SACL counsellors can sometimes attend in a crisis capacity and offer onsite support – for example, be present to support the consumer while discussing the incident with staff or family members, medical examinations, police interviews and so on. CASA/SACL can also offer advice about the rights of the person(s) impacted and the processes around police reporting. If the impacted person chooses not to contact CASA/SACL immediately, offer them the opportunity to contact CASA at a later stage. Referral to these services is highly recommended but voluntary.

Advise the consumer that, when CASA/SACL is contacted, they will:

- be believed
- be treated with respect, sensitivity and understanding
- not have to share more information than they are comfortable with
- be in control of their decision making
- have privacy and confidentiality.

Staff should also consider contacting CASA/SACL following a sexual safety incident for secondary consultation and advice about how to support the person(s) impacted, and about police processes, forensic medical examinations and so on.

Legal and non-legal advocacy options

Offer all consumers who have been involved in a sexual safety incident, options for legal and non-legal advocacy.

- Provide information on how to access legal assistance and representation

- [Victoria Legal Aid](https://www.legalaid.vic.gov.au/) <https://www.legalaid.vic.gov.au/> phone 1300 792 387
- [Mental Health Legal Centre](https://mhlc.org.au/) <https://mhlc.org.au/> phone (03) 9629 4422
- Provide information about different avenues for making a complaint and accessing advocacy (refer to part [7.1 \(Making a complaint and access to advocacy\)](#) of this document)
- Provide support to make a statement to Victoria Police – refer to part [5.1 \(Reporting to police\)](#) of this document.

Safety planning

Following a sexual safety incident, revisit planning with all involved consumers, including any witnesses. Follow actions in safety plans as appropriate and update as necessary. Refer to part [3.4 Safety planning for sexual safety](#) of this document.

4.2.2 Communicating with families, carers and supporters

Provide general information and education about sexual safety in the service to families, carers and supporters on admission. This should include information about:

- the service's duty of care to ensure sexual safety
- local sexual safety policies
- how families, carers and supporters can support consumers' sexual safety during admissions
- services' reporting obligations.

Tailor information to the needs of families, carers and supporters. Also provide advice on how to contact the service to discuss any sexual safety concerns that may emerge during the admission.

Sharing personal or health information must be done in line with the consumer's preferences to the greatest extent possible and in line with the information sharing provisions under Part 17.1 of the Act. Clinical mental health service providers should also identify if there is a nominated support person and ensure that they are enabled to fulfill the requirements of that role and provided information to enable this under Part 2.6 of the Act. Consideration should also be given to the information sharing limitation if there may be a risk of family violence under Part 1.6 of the Act whereby information must not be shared if the service forms a reasonable belief that this may cause or escalate a family violence risk. This limitation applies even when the consumer has consented to disclosure of information.

If sharing information is possible under these provisions, families, carers and supporters of consumers involved in sexual safety incidents should be contacted as soon as practicable. This includes person(s) impacted, alleged instigator(s) and witnesses. Staff must endeavour to maximise the consumer's choice and control around how this is done. When considering the consumer's wishes and preferences for sharing information about a sexual safety incident consider:

- any history of family violence including sexual violence
- LGBTIQ+ consumers' concerns about their sexuality or gender identity being revealed to their families
- cultural beliefs about sexual activity and/or negative cultural consequences.

If the consumer consents, families, carers and supporters may wish to be present with the consumer throughout the service response to the incident, including:

- while the consumer describes the incident to staff
- when collecting evidence
- during a medical or forensic medical examination

- during any police statement or interview.

Staff must ensure families, carers and supporters get detailed information about the service response to sexual safety incidents; also consider their views and preferences. Engagement should occur through various means including formal family meetings when possible. Families, carers and supporters are enabled to provide extra support to consumers following sexual safety incidents through extended visiting hours or extra leave as appropriate.

Services must also consider the enormous impact on families, carers and supporters. Offer appropriate support and referrals, including support from a family/carer lived experience worker and referral to the CASA/SACL friends and family resources.

4.2.3 Medical examinations after an incident

Following a sexual safety incident, a medical examination assesses the consumer's physical and mental health needs and immediate treatment and support needs.

In bed-based services that do not have medical staff onsite – for example, PARCs or CCUs – consider the most appropriate way to access medical support. This may be via the on-call psychiatrist, through supported attendance with a GP, emergency department (ED) or crisis care unit (available at some EDs specifically for forensic medical examinations).

The purpose of an immediate medical examination is to assess physical and psychological harm. The purpose of this medical review is **not** to collect forensic evidence. If a forensic examination is called for, contact Victorian Institute of Forensic Medicine (VIFM). Where possible the consumer should have their choice of medical practitioner. Also consider the following:

- The medical review should occur as soon as practicable, considering the consumer's preferences. This will help ensure the health and safety of the consumer as well as assisting to gather information that other agencies may require.
- Consider the most appropriate location for the examination (for example, in the acute unit or in an ED) and medical practitioner (for example, consumer preference for gender of practitioner).
- Get the consumer's consent before conducting a medical examination. A physical examination cannot occur without the consumer's consent regardless of their status under the Act.
- Give the consumer the opportunity to have a support person present for examinations.
- Thoroughly and accurately document the findings from the medical examination.

Discussions of the potential requirement for a medical examination, particularly internal examinations, can be traumatising. This can be particularly distressing for trans, intersex or gender diverse consumers if they feel their bodies do not meet gender norms or societal expectations. Offer consumers appropriate support and reassurance.

If there has been sexual activity that may result in pregnancy or disease transmission, discuss these possibilities with the consumer. Recommend testing. Under this guideline, Prophylactic treatment **must** be offered and emergency contraception **must** be offered or arranged within 72 hours to consumers who are at risk of unwanted pregnancy. Note that any pregnancy, even if it is a result of sexual assault, may be wanted, and the consumer's wish and right to continue a pregnancy is to be discussed and upheld.

Consultation with the hospital's infectious diseases department or sexual health physician is recommended:

- The [Melbourne Sexual Health Centre](https://www.mshc.org.au/) can provide information to health professionals.
<<https://www.mshc.org.au/>>

- Also refer to [1800 My Options](https://www.1800myoptions.org.au/) for information on reproductive health options including contraception <<https://www.1800myoptions.org.au/>>.
- Staff can also get advice from [Centre Against Sexual Assault \(CASA\)](https://www.casa.org.au/) <<https://www.casa.org.au/>> or [Sexual Assault Crisis Line \(SACL\)](https://www.sacl.com.au/) <<https://www.sacl.com.au/>>
- The [Victorian Institute of Forensic Medicine](https://www.vifm.org/) can provide advice on forensic and non-forensic medical examinations following a suspected or alleged sexual assault and secondary consultation with this service is strongly recommended. Call (03) 9684 4444 or for more information go to <<https://www.vifm.org/>>

4.2.4 Assessing decision-making capacity

It is necessary to assess the consumer's capacity to make certain decisions. This assessment should be ongoing and be considered in relation to each decision. This is **not** an assessment of the person's capacity to consent to sexual activity.

Give consumers adequate information and support (for example, from CASA/SACL) to understand their options and to make informed decisions. If a person does not have decision-making capacity, they should still be involved in and informed about decisions that affect them.

After a sexual safety incident, conduct a mental status examination including a capacity assessment for all involved parties. Ensure the authorised psychiatrist or delegate documents this. In services where review with a psychiatrist is not immediately available, a mental health clinician should undertake a mental state assessment and arrange for involved consumers to see a psychiatrist as soon as possible. Psychiatric assessment should evaluate the consumer's capacity to:

- consent to the physical health examination and care
- understand the police reporting process
- attend a police interview (considering any likely detrimental effects)
- collaborate with an investigation.

4.3 Responding to different parties

Several consumers may be involved in a sexual safety incident, and the service response to them will vary depending on their role in the incident. Consider also responding to staff and visitors who have been involved in sexual safety incidents.

4.3.1 Responding to person(s) impacted

A person impacted by a sexual safety incident may be a consumer that was involved in sexual activity in a bed-based mental health service where this is prohibited, or a person who alleges or is suspected or witnessed to have been a victim of sexual assault or sexual harassment.

It is common that person(s) impacted cannot provide a fully detailed or linear account of sexual safety incidents due to the impacts of trauma on recall. This is even more likely in a mental health environment where consumers may be experiencing acute symptoms of mental illness and are more likely to have past experiences of trauma. This should not prevent incidents from being fully and appropriately responded to.

When responding to an impacted person, make sure they have as much choice and control over decision making as possible. Be transparent about decisions that the service may need to make – for example, about reporting to police.

- Where possible the consumer should choose the staff member who provides the immediate response to the incident, and staff must ensure there is enough time to hear and respond to the victim-survivor's account.
- Let them know you believe them.
- Offer access to a support person as soon as possible (for example, family or a carer, lived experience worker, or a CASA counsellor).
- Be alert to any barriers to disclosure (for example, concerns about privacy), and address these with the consumer. Be transparent about how the service will respond.
- Do not make excuses for the alleged perpetrator (for example, about their intention or mental state).
- Ensure the affected person is not further exposed to the alleged instigator. This may mean separating consumers through operational decisions including the alleged instigator being transferred out of the unit.
- Enable the person to speak with CASA or police if they prefer.

4.3.2 Responding to alleged instigators who are consumers

Alleged instigator is a consumer who is alleged or suspected to have perpetrated sexual assault or harassment. This may occur in a range of circumstances from instances where there is a clear allegation of sexual assault or harassment, to cases where it was later alleged that the sexual activity was not consensual. The alleged instigator may have believed they were engaging in consensual sexual activity. Respond to the alleged instigator in a sensitive and non-punitive way.

Staff must respond immediately to the consumer's alleged behaviour.

- Continue appropriate support and care, ensuring fair and reasonable treatment.
- Allow the alleged instigator to give their account of events and circumstances about the incident.
- Inform the alleged instigator that there may be police involvement and support them to get legal advice.
- Ensure the consumer understands that sexual activity of any kind is not permitted (in nearly all service settings) and remind them of the expected behaviour. Reiterate that sexual safety for everyone in the service is of utmost importance.
- Take safety measures such as increasing observations of the alleged instigator or placing them in a high-visibility area such as an intensive care area.
- Review and act on risk assessments and safety plans.
- Consider moving the alleged instigator to a different unit/hospital away from the victim-survivor.
- In some settings – for example, PARCs or CCUs – it may be necessary to transfer the alleged instigator to another care environment or to discharge them with intensive community support.
- Use the [Safewards](https://www.health.vic.gov.au/practice-and-service-quality/safewards-training-resources) <https://www.health.vic.gov.au/practice-and-service-quality/safewards-training-resources> 'calm down methods' (for example, sensory rooms or sensory modulation) and 'talk down' interventions before other strategies such medication (as required) or containment (restrictive interventions), which may traumatise the person further.
- Inform the person's family, carer or supporter. Consider any risk implications of the incident for the family – for example, in instances where there are family violence or child protection

concerns or how disengagement from services may affect the family's ability to support the consumer.

4.3.3 Responding to involved parties where there is no clear person affected or alleged instigator

In some incidents there is not a clear affected person or an alleged instigator – for example, in cases of seemingly consensual sexual activity or if a consumer unwittingly exposes themselves to a staff member. In these instances, there may be one or more vulnerable people who are affected.

The interventions outlined in this guideline should still apply in these circumstances.

It is important for services to stay mindful that consumers who initially report that they engaged in sexual activity consensually may later reflect that they did not, or were not able to, consent at that time. This can occur in any service setting and should be discussed openly with consumers. Staff should be particularly aware of power imbalances or potentially coercive situations. Staff should provide information about how consumers can pursue legal action or contact CASA at a later stage if they do not wish to do so immediately. Seemingly consensual sexual activity in most bed-based clinical mental health services should in many cases be reported to the police (refer to section [5.1 Reporting to police](#)). If incidents are disclosed in other bed-based environments, they must be thoroughly and accurately documented in medical records / case notes. This can support consumers who decide to pursue legal action later.

4.3.4 Other parties: staff, visitors and witnesses

Staff as the person(s) impacted

When staff are person(s) affected by sexual safety incidents, take the following actions:

- Follow all advice in this guideline in relation to escalation and documentation.
- Offer support with reporting/paperwork to staff who have been impacted by a sexual safety incident.
- Have the person's line manager (or other senior staff member) offer support / a debriefing
- Consider whether the incident impacts on the staff member's ability to continue their shift. Offer the option of ending their shift early.
- Inform staff of their right to report to police and offer them support to do so if they wish.
- Discuss available supports: the Employee Assistance Program (EAP), Nursing and Midwifery Health Program, Nurses and Midwife Support, Victorian Doctors Health Program, CASA.
- Remember that sexual safety incidents can be extremely distressing for everyone, and there may be substantial impacts on staff wellbeing. Some staff may also have past experiences of sexual violence, and this can make sexual safety incidents particularly distressing.
- CASA may be able to facilitate reflective sessions for the whole treating team if there are frequent or repeated incidents.

Staff as alleged instigators

In most circumstances it is a criminal offence for a staff member at a mental health and wellbeing service to intentionally engage in sexual penetration with a consumer (section 52B of the [Crimes Act 1958](#) < <https://www.legislation.vic.gov.au/in-force/acts/crimes-act-1958/302>>) or intentionally engage in sexual touching with a consumer (section 52C of the Crimes Act). If these sorts of

incidents occur, the service must report them to the police and, irrespective of police involvement, disciplinary and potentially registration issues will need to be addressed.

Services must have local protocols for responding to allegations of sexual safety incidents perpetrated by staff. Take these incidents seriously. Investigate thoroughly.

- Immediately report all instances of sexual safety incidents where a staff member is an alleged or suspected perpetrator to senior management.
- Senior management must report the incident to Victoria Police and follow any internal reporting requirements (refer to section [5.1 Reporting to police](#)).
- Eliminate all further contact or association between the consumer and the staff member (the staff member should be moved or removed, not the consumer). The consumer is only to be moved to a different unit if they request this.
- Senior management must notify the alleged perpetrator's relevant registration body – for example, [Australian Health Practitioner Regulation Agency \(AHPRA\)](https://www.ahpra.gov.au/) <<https://www.ahpra.gov.au/>>.
- Inform the staff member of the allegation, the service's responsibility to investigate, how the investigation will proceed, and the implications for the staff member.
- Protect the staff member's rights and give advice about the supports available to them (for example, union or EAP).

Visitors

Visitors to the service may be witnesses, victim-survivors or alleged perpetrators. When visitors are involved in a sexual safety incident, services must:

- record the visitor's details
- report the incident in the same ways as other sexual safety incidents, and record it in the medical record of the involved consumer
- if the visitor is a victim-survivor, staff should offer information about the visitor's right to report the incident to the police or support available from CASA
- if the visitor is an alleged perpetrator, services must investigate and, if relevant, consider how they can support the consumer to keep safe in their relationship with the visitor
- report to the police in line with this guideline (part [5.1 Reporting to police](#) of this document).

Witnesses

- Identify witnesses and document their details so police can be informed if relevant.
- Give all witnesses the opportunity to provide staff with their account of what happened.
- Offer witnesses support as appropriate (offer direct support to a witness who is a consumer or debriefing to a staff member).

4.4 Escalation, handover, debriefing and open disclosure

4.4.1 Escalation and handover

Escalate all sexual safety incidents to senior staff in line with local protocols. In general, staff should immediately notify the nurse unit manager or manager on site, who must notify the authorised psychiatrist or delegate, area manager and director of clinical services. After-hours protocols may include notifying the hospital after-hours coordinator and on-call manager. These processes may vary across different service types; for example, PARCs operate in partnership with non-clinical

mental health and wellbeing services and may have dual reporting requirements. Involve senior staff in key decision making, reporting, and open disclosure processes.

Discuss incidents in handover. Thoroughly document these discussions.

4.4.2 Debriefing

Senior management should ensure support and debriefing is offered to everyone affected, directly or indirectly, within the first 72 hours, but ideally within the first 24 hours after a sexual safety incident occurs. This includes consumers, family, carers and supporters, and staff.

Check for and follow local policies and procedures for critical incident debriefing.

4.4.3 Open disclosure

Open disclosure is the process of discussing an adverse event that resulted in harm. This is done with the consumer and, if appropriate, their family, carers and supporters. This discussion must include an apology or expression of regret from the health service, as well as a factual explanation of the event and the steps being taken to stop it happening again.

Open disclosure must occur after all sexual safety incidents, and in some circumstances, the requirements of the Statutory Duty of Candour (SDC) will apply (refer to [Part 4.4.4 Serious adverse patient safety events](#) of this document). It is extremely important that open disclosure occurs in a way that is accessible for all consumers. Think about the communication needs of consumers and their families, carers and supporters. Accessible and transparent communication should continue throughout the process of responding to a sexual safety incident.

Health services must have local policies and procedures for open disclosure.

4.4.4 Serious adverse patient safety events

Mental health and wellbeing service providers are now legally required to provide consumers and, in certain circumstances, their next of kin, carer or nominated person with the Statutory Duty of Candour (SDC²) when a consumer has experienced a 'serious adverse patient safety event' (SAPSE).³ The SDC builds on the principles of open disclosure to ensure consumers are communicated with openly and honestly, and that staff feel safe to speak up when adverse events occur.

Under section 128ZC (1) of the *Health Services Act 1988*, the health service entity responsible for providing health services where the serious adverse patient safety events (SAPSE) occurred must provide the consumer with:

- a written account of what happened
- an apology for the harm suffered by the consumer
- a description of the service's response to the event
- a description of the steps taken to prevent the event reoccurring.

² Under section 3(1)(a) of the Act, the duty of candour in relation to the provision of mental health and wellbeing services by a mental health and wellbeing service provider other than Forensicare, is the duty of candour specified in Division 9 of Part 5A of the *Health Services Act 1988*. The equivalent duty of candour for Forensicare is specified in Part 14.4 of the Act.

³ For the full definition of SAPSE, refer to Regulation 3B of the Health Services (Quality and Safety) Regulations 2020.

In addition to the above, the health service must also comply with any requirements and timelines set out in the [Victorian SDC guidelines](https://www.safercare.vic.gov.au/e-learning/duty-of-candour) <<https://www.safercare.vic.gov.au/e-learning/duty-of-candour>>.

5. Reporting and documenting

Documenting sexual safety incidents is extremely important because it may provide evidence for future legal proceedings. Ensure documentation is clear, factual, thorough and accurate.

Under this guideline, documentation must include:

- incident type, description and the time, date, place of the incident
- an account from all involved parties
- clear differentiation between incidents suspected, reported, or observed
- the response to the incident – for example, support, referrals or treatment offered
- internal and external reporting undertaken
- a record of contacting family, carers or supporters. If it was decided not to make this contact document the rationale for this.

Descriptions and terminology should:

- be verbatim accounts from the parties involved where possible
- be objective regarding mental state and behaviour, without judgement⁴
- affirm the person's identity by using their preferred name and pronouns and acknowledging their specified partner, and other family members and nominated person if applicable (this may be different from previous medical records).

5.1 Reporting to police

For some sexual safety incidents, reporting to police is mandatory (see below). In some cases, if staff are concerned about the appropriateness of a police report, escalate the matter to the authorised psychiatrist or their delegate or senior mental health clinician. Consider the supported decision-making principles (Part 3.1) and the mental health and wellbeing principles (Part 1.5) of the Act.

5.1.1 Discussing police reporting with consumers

When discussing the process of making a report to police, staff must:

- inform consumers and support them to access CASA/SACL (refer to [4.2.1 Referral to specialist services](#) part in this document)
- discuss the benefits of reporting to police and discuss any concerns consumers and their family, carers and supporters may have
- seek the consumer's consent to making a police report (if they are the affected person) and advise them that reporting may occur even without their consent and why this may happen.

⁴ Examples of judgemental language not to be used include describing someone as 'dressed provocatively' or describing behaviour as 'promiscuous'. Instead describe the actual words and behaviours, without using unnecessarily clinical language, overlaying interpretation or using emotive language.

Open and transparent discussion is part of supported decision making and may alleviate some of the reasons a consumer may have for not wanting to report to police. Be mindful of trauma-informed care principles.

If the consumer consents to police reporting or wants to report, this **must always** be supported, including when there is little, or no evidence and the disclosure seems implausible.

5.1.2 Mandatory police reporting

If any of the following factors/circumstances are present a police report **must** be made:

- the affected person wants to report to police
- there is physical evidence of assault or CCTV footage
- physical harm has occurred
- the service believes the affected person may be under duress not to report to police (for example, from another consumer, carer or visitor)
- future incidents are likely (for example, due to predatory behaviour or continued mental state disruption)
- other parties to the sexual safety incident (for example, witnesses) want it reported to police
- If it is suspected or alleged that a person under 16 years of age may have been sexually assaulted.

5.1.3 Escalating the decision to report to police to the authorised psychiatrist or delegate

If none of the above factors/circumstances are present, and the consumer does not want to report to police, escalate the decision to the authorised psychiatrist or delegate. The decision to make a report to the police without consent may occur on a case-by-case basis under a range of circumstances. Under this guideline, the risks and benefits of reporting to police must be considered including:

- the consumer's right to privacy and reputation⁵
- the consumer's right to protection from cruel, inhuman or degrading treatment⁶
- the consumer's decision-making capacity regarding the police reporting decision
- the impact on the consumer of having their choice and control being taken away
- the consumer's previous negative law enforcement experiences (LGBTIQ+ people may have increased fear of discrimination and harassment, disclosing sexuality or gender identity, or not being able to record names not legally changed on forms)
- that an allegation of sexual assault may eventuate even in cases where both consumers believe and assert that the sexual activity was consensual and there are no indications otherwise (for example that one party was known to be acutely unwell)
- that an allegation of sexual assault may still eventuate even if the consumers (both parties) believe and assert that the sexual activity was consensual, and there are no indications that this is not the case.

⁵ Section 13 of the *Charter of Human Rights and Responsibilities Act 2006* (Vic).

⁶ Section 10 of the *Charter of Human Rights and Responsibilities Act 2006* (Vic).

5.1.4 Reporting to police without consumer consent

If a decision is made to report to police against the consumer's wishes, the consumer, and their family, carer or supporter, should be clearly informed this is taking place and any consequences arising from the police process must be explained. Advise the consumer(s) that if a police report is made without their consent, they can choose whether to engage with police and police processes.

5.1.5 If a police report is not made

If the affected person does not want to report to the police and authorised psychiatrist or delegate decides not to report to police without consent, clear reasons for this decision, must be recorded. Complete all other reporting procedures. Inform consumers of:

- the option of reporting to police at a later date
- how they can access documentation regarding the incident (freedom of information processes)
- any possible legal implications of delayed reporting (for example, access to victims of crime compensation).

5.2 Supporting police investigations

Services must do everything they can to support police investigations. Please refer to [Chief Psychiatrist's guideline police interview or court attendance](https://www.health.vic.gov.au/practice-and-service-quality/police-interview-or-court-attendance) <https://www.health.vic.gov.au/practice-and-service-quality/police-interview-or-court-attendance> where there is an allegation.

5.2.1 Preserving evidence

Police can provide advice for preserving evidence, and services should discuss police advice with victim-survivors.

If police are attending, their advice may include the following:

- Discourage the affected person from showering, washing their hands, rinsing their mouth, brushing their teeth or changing their clothes.
- Seal off the room or location where the offence is alleged to have occurred.
- If the victim/survivor feels compelled to change their clothes before police arrive, bag and seal the clothing and give it to police as evidence.
- Record the details of all parties including witnesses and give this to police.

These steps also apply to any evidence obtained from the alleged perpetrator or other party. Explain the preservation of evidence process to all parties and that they have a right to advocacy.

5.2.2 Victorian Institute of Forensic Medicine (VIFM) and Victorian Forensic Paediatric Medical Service (VFPMS)

Forensic medical examination

If police recommend a forensic medical examination, offer this option to the affected person. Remind them of the option to have a support person of their choice with them. Staff, CASA/SACL or police must explain to the victim/ survivor what this entails. A patient must not be examined for forensic purposes without valid consent. However, staff should get advice from VIFM or VFPMS on what to do regarding forensic examinations if the consumer's decision-making capacity is impaired (refer to part [4.2.4 of this document Assessing decision-making capacity](#)).

VIFM forensic medical examiners gather information and evidence for criminal or other court proceedings and undertake tests for sexually transmitted infections (STIs) and pregnancy if appropriate. Forensic medical examiners will also treat any immediate medical needs. Health, wellbeing and attending to immediate medical needs take precedence over the forensic aspect.

Consider the most appropriate location for a forensic medical examination. Crisis care units, found in some EDs, take forensic samples and reduce the risk of contamination. If it is not appropriate to move the person, then VIFM can attend the mental health service. There will be different considerations depending on whether the service is located on hospital grounds and discuss these with VIFM.

Secondary consultation

Medical staff are encouraged to consult with VIFM or VFPMS. This secondary consultation is extremely useful in a range of circumstances – for example, if they are providing medical care before a forensic medical examination. Both services operate 24/7 phone lines:

[Victorian Forensic Paediatric Medical Service \(VFPMS\)](https://www.rch.org.au/vfpms/), phone 1300 661 142; <<https://www.rch.org.au/vfpms/>>

[Victorian Institute of Forensic Medicine \(VIFM\)](https://www.vifm.org/), phone (03) 9684 4480; <<https://www.vifm.org/>>

5.3 Reporting to Child Protection

For more information refer to:

- [Children, Youth and Families Act \(2005\)](http://classic.austlii.edu.au/au/legis/vic/consol_act/cyafa2005252/) <http://classic.austlii.edu.au/au/legis/vic/consol_act/cyafa2005252/>
- [Protecting Children: Protocol between Department of Human Services – Child Protection and Victoria Police](https://www.cpmanual.vic.gov.au/sites/default/files/Protecting-Children-CP-and-VicPol-protocol-2012-2825.pdf) <<https://www.cpmanual.vic.gov.au/sites/default/files/Protecting-Children-CP-and-VicPol-protocol-2012-2825.pdf>>
- [Child Information Sharing Scheme](https://www.vic.gov.au/child-information-sharing-scheme) <<https://www.vic.gov.au/child-information-sharing-scheme>>.

All services must have policies and procedures that cover staff responsibilities in making reports to Child Protection. This applies in cases where staff reasonably believe that a child (under 16 years of age) has suffered or is likely to suffer significant harm as a result of physical injury or sexual abuse, and the child's parents are unable or unwilling to protect the child. Local policy must address considerations for staff who are mandatory reporters (doctors and nurses under s 182(1)(a) and (b) and 184(1) of the [Children, Youth and Families Act 2005](https://www.legislation.vic.gov.au/in-force/acts/children-youth-and-families-act-2005/135) <<https://www.legislation.vic.gov.au/in-force/acts/children-youth-and-families-act-2005/135>>) and staff who are not mandated (for example, social workers and lived experience workers).

If a child is involved in a sexual safety incident while in a bed-based mental health service, this does not automatically lead to a notification to Child Protection. However, concerns for a child's safety may arise in ensuring their safety in bed-based clinical mental health service. Issues to consider include:

- whether the child's sexual behaviour is unusual or not age appropriate without explanation
- the child's parent(s) or guardian does not act in a way that is adequately protective of the child's safety
- the child discloses that they have been physically or sexually abused while in the care of their parent(s) or guardian

- there is a suspicion that the child has been physically or sexually abused while in the care of their parent(s) or guardian (this may be based on a direct disclosure or a suspicion that develops in relation to the child's behaviour)
- staff become aware of family violence
- staff become aware of parental substance use, psychiatric illness or intellectual disability that is impacting on the child or young person's safety, stability or development
- a child shows signs of being physically or sexually abused, such as a physical injury with concerns it was non-accidental or is insufficiently explained
- the child is in contact with a person whose criminal history leads to a reasonable assumption that the child may be at risk of physical or sexual abuse because of this contact.

5.4 Reporting to the incident management system and Chief Psychiatrist

All sexual safety incidents that occur in bed-based clinical mental health services, including those in custodial settings must be reported via the Victorian Health Incident Management System (VHIMS) and to the Chief Psychiatrist. These reporting processes are important to ensure that escalation and oversight are appropriately provided. However, attending to the safety and immediate needs of involved parties must take priority and reporting must not interfere with these processes. Refer to [Chief Psychiatrist's reporting directing: reporting sexual safety incidents to the chief psychiatrist](https://www.health.vic.gov.au/chief-psychiatrist/improving-sexual-safety) <<https://www.health.vic.gov.au/chief-psychiatrist/improving-sexual-safety>>

6. Transfer of care (discharge) planning and referrals

Ensuring that incidents are thoroughly and accurately documented, and information is shared appropriately, is important to ensure consumers have their needs met beyond the acute phase, or outside of the bed-based environment.

6.1 Handover to other services

Transfer information about the sexual safety incident to community teams or services (or other service types as applicable – for example, PARCs or CCUs) so they can offer appropriate follow-up care and support to the consumer. This includes for any consumer who has been involved in an incident (affected persons, witnesses, alleged instigators). Information should include the nature of the alleged incident, any legal proceedings, the service response, the open disclosure processes and access to advocacy services. Share this information through local procedures such as discharge plans but also via a verbal handover to the community treating team. Information should detail the incident itself as well as the progress on follow-up actions, such as STI tests, referrals to CASA or police involvement. For consumers who have case management, engagement with community teams throughout admissions is encouraged. Staff in bed-based services and staff from involved community teams should stay in regular contact throughout admissions. These practices offer opportunities for community staff to provide continuity of care and contribute to sexual safety incident responses and safety planning processes.

6.2 Transfer of care (discharge) documentation

Information about sexual safety incidents that occurred during a consumer's admission are usually documented in the transfer of care plan or discharge summary. Weigh the consumer's preference or right not to disclose with the need to provide information necessary for ongoing treatment and support post-discharge. Discharge plans and summaries should clearly identify ongoing needs and clear steps on how to meet them, including any ongoing vulnerabilities and risks.

Consumers who have been involved in sexual safety incidents in acute settings should be given the opportunity to prepare an advance statement that identifies their care preferences for future acute admissions in light of their experience. For consumers in other bed-based services, consider how they can be supported to plan for their safety.

Refer to the [Chief Psychiatrist's guideline on Transfer of Care and Shared Care](https://www.health.vic.gov.au/chief-psychiatrist/transfer-of-care-and-shared-care)
<<https://www.health.vic.gov.au/chief-psychiatrist/transfer-of-care-and-shared-care>>

6.3 Referral to external services

Upon discharge, offer consumers referrals to appropriate external services. Consider their ongoing medical and psychological needs – for example, sexual health clinics for follow-up STI testing. Provide sufficient information that consumers can follow up with referrals – for example, to CASA, later if desired.

6.4 Families, carers and supporters

Because consumers are often discharged into the care of families, carers and supporters, pay attention to their support needs in their caring role following discharge. Sexual safety incidents are distressing for families, carers and supporters, so offer referral pathways with active support to link into these services, including a referral to CASA.

7. Other considerations

7.1 Making a complaint and access to advocacy

Provide consumers, families, carers and supporters with rights-based information about how to make a complaint or access advocacy at any stage of their engagement with mental health and wellbeing services. Consumers may complain about any aspect of their sexual safety, regardless of whether a sexual safety incident has occurred.

- **Making an internal complaint** – provide information about the process for making a formal complaint within the service, provide necessary paperwork and offer support to complete it, or facilitate a formal verbal complaint.
- **Making a complaint to the Mental Health and Wellbeing Commission (MHWC)**. The MHWC can receive complaints over the phone 1800 246 054 or by [emailing the MHWC help desk](mailto:help@mhcc.vic.gov.au) <help@mhcc.vic.gov.au>. For more information refer to the [MHWC website](https://www.mhwc.vic.gov.au) <https://www.mhwc.vic.gov.au>. Staff must help consumers if they wish to contact the MHWC.
- **Australian Health Practitioner Regulation Agency (AHPRA)** – if the complaint is about an AHPRA-registered staff member. For more information refer to the [AHPRA website](https://www.ahpra.gov.au/About-Ahpra/Complaints.aspx) <https://www.ahpra.gov.au/About-Ahpra/Complaints.aspx>.
- **The Mental Health Legal Centre** can be contacted on (03) 629 4422 or 1800 555 887 (free call from rural Victoria) or for further information visit the [MHLC website](https://mhlc.org.au/) <https://mhlc.org.au/>.
- **Independent Mental Health Advocacy (IMHA)** by phoning 1300 947 820 or visit the IMHA website <https://www.imha.vic.gov.au/> or the **Victorian Mental Illness Awareness Council (VMIAC)** by phoning (03) 9380 3900 or visit the [VMIAC website](https://www.vmiac.org.au/) <https://www.vmiac.org.au/> to support the complaints processes.
- Obtain medical records via the **freedom of information** process to help form a complaint and compile the evidence to support it.

Part 2: Principles of care for sexual safety

The principles of care outlined in this section should be applied to all activities of preventing and responding to sexual safety incidents and are aligned with the principles outlined in the Act. When providing treatment care and support mental health and wellbeing services must make all reasonable efforts to adhere to the mental health and wellbeing principles (part 1.5 of the Act). Mental health and wellbeing services also have a statutory responsibility to and consider the decision-making principles (part 3.1 of the Act) and to document how these principles were considered.

Part 2 of this guideline should be used to inform local policy and practice development. The information in this section must also be used by clinical mental health service providers when undertaking capital works or building new bed-based facilities.

1. Why is sexual safety important?

Sexual safety is a critical part of recovery. Inappropriate and unwelcome sexual activity is damaging to the mental health and wellbeing of consumers and their families, carers and supporters, plus it significantly erodes trust in services. Orientation, training and education is required to enable service providers to create safe and inclusive care environments.

1.1 Gender-based violence

Sexual violence is often gender-based violence, with women and trans and gender diverse people more likely to report experiences of sexual violence, including in mental health and wellbeing services. Cisgender men are more likely to be alleged perpetrators.⁷ However, there are also very vulnerable men in mental health and wellbeing services, and men can be victim-survivors of sexual violence. Men may be less likely to report sexual safety incidents, and sexual vulnerability may not be as easily identified as it is in women.

1.2 Trauma

A large proportion of mental health service users have histories of experiencing sexual violence, often including childhood sexual abuse. This increases people's risk of further sexual violence including in inpatient units.⁸ Consumers with a history of trauma may:

- be more at risk of exploitation
- find it difficult to defend against or repel advances by other consumers
- be motivated to seek connection by forming potentially unsafe relationships.

⁷ Mental Health Complaints Commissioner (2018). *The right to be safe*, MHCC, Melbourne.

⁸ Quinn C, Happell B (2015). Exploring sexual risks in a forensic mental health hospital: Perspectives from patients and nurses. *Issues in Mental Health Nursing*, 36(9), 669–677; McGarry J (2019). 'Hiding in plain sight': Exploring the complexity of sexual safety within an acute mental health setting. *International Journal of Mental Health Nursing*, 28, 171–180.

1.3 Consequences of sexual safety incidents

There are substantial and far-reaching harmful consequences to people affected by sexual safety incidents (emotional, psychological, social and economic) if sexual safety is not addressed. There are also significant consequences, including potential legal consequences, for alleged perpetrators. Sexual safety incidents can have the following impacts:

- compounding the impact of previous trauma
- negative effects on mental health and recovery
- significant and long-lasting health effects
- immediate risk of injury, STIs and pregnancy
- adult chronic disease, which has been linked to childhood and cumulative trauma, including sexual assault in adulthood
- changes to help-seeking behaviour for mental health support
- a public health impact and cost, with more long-term poverty, disability pension use, mental health admissions, divorce, post-traumatic stress disorder and other mental health conditions.⁹

2. Principles of care

Implement this guideline in line with the mental health and wellbeing principles under part 1.5 of the Act including supported decision making, least restrictive, family and carer, diversity, gender safety, and cultural safety principles. To achieve this, approaches to care must be of trauma-informed and recovery-oriented. Services must also be provided in line with human rights including the right to humanity and dignity, the right to freedom from discrimination, and the right to be protected from torture and cruel, inhuman or degrading treatment.¹⁰

Mental health and wellbeing services must aspire to promote awareness and understanding of sexual health and sexuality, across workforce and consumer groups including understanding of consent and healthy intimate relationships.

2.1 Different care environments

There are different considerations for different consumer cohorts depending on factors like age, service type and service setting.

Below are some considerations for specific environments and population groups.

Child (< 13)	<p>Early and supportive parental or guardian involvement in all stages of promoting sexual safety is crucial, including preadmission contact and involvement in orientation.</p> <p>Orientation information and sexual education must be age/developmentally appropriate and should focus on healthy boundaries, personal space and respecting privacy.</p> <p>Children with histories of sexual abuse or family violence can be susceptible to becoming victim-survivors or emulating sexual perpetrator behaviours (must assess</p>
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⁹ Mental Health Complaints Commissioner (2018). *The right to be safe*, MHCC, Melbourne, p.18.

¹⁰ Sections 7(2), 8 and 10 of the *Victorian Charter of Human Rights and Responsibilities* (2006)

	<p>risks of both). Any sexualised behaviour is to prompt reassessment of risk and safety plans.</p> <p>Involve children in developing their own safety plan wherever possible, including to reflect their views and wishes.</p> <p>Staff may at times need to proactively share information relevant to broader safety and wellbeing issues for children and must be aware of the Child Information Sharing Scheme <https://www.vic.gov.au/child-information-sharing-scheme>.</p>
<p>Young people (13–25)</p>	<p>Orientation to services and sex education for young people includes:</p> <ul style="list-style-type: none"> • discussing the use of technology for sexual purposes • talking about the consequences of sexual activity on the unit • information on healthy boundaries • understanding what constitutes sexual harassment and assault • education about the criminal nature of some sexual behaviours. <p>Discussion may include families, carers and supporters or guardians, in alignment with the choices and preferences of the consumer and considering the age of the consumer.</p> <p>Admitting young people (18–25 years) to an adult unit can create unique sexual safety risks requiring extra care to ensure sexual safety is considered in risk assessment and safety planning. Involve young people in their own safety planning, but they may need extra help in identifying their own resources and developing realistic safety plans.</p>
<p>Older people</p>	<p>When providing orientation to older consumers or undertaking risk assessments and safety planning it is extremely important to engage families, carers and supporters because they are often very involved in the consumer’s care. In all cases it is important to ensure the right family member, carer or supporter, determined in consultation with the consumer, is involved.</p> <p>Sexual education is often overlooked for this cohort but should be delivered sensitively and when indicated. Also consider LGBTIQ+ needs for this age group related to:</p> <ul style="list-style-type: none"> • orientation to the service • sex education • engaging with families, carers and supporters • risk assessments and safety planning. <p>LGBTIQ+ consumers in this cohort are likely to have had difficult life experiences in relation to sex, sexuality and gender identity.</p> <p>Older people are also more likely to have complex health problems. Behavioural and psychological symptoms of dementia include:</p> <ul style="list-style-type: none"> • inappropriate sexual behaviour • disrobing • intrusiveness • wandering • physical frailty and mobility issues • sensory communication deficits (hearing, sight and speech). <p>These factors may increase sexual vulnerability or risk. Consider these in risk assessment and safety planning.</p>
<p>SECU</p>	<p>The length of stay in these services requires frequent revisiting of orientation information combined with longer term education and discussions of sexual health and safety. Regularly revisit:</p>

	<ul style="list-style-type: none"> • orientation information • risk assessment • safety planning. <p>Consider acute and non-acute periods. Sexual education and non-judgementally supporting consumers to engage in safely in relationships is especially important in this setting.</p>
PARC	<p>Clinical services should work together with non-government providers to ensure that orientation and sexual education are provided.</p> <p>PARCs should seek advice from acute services (if recently involved) about risk assessments and safety planning, including information on any sexual safety incidents that occurred in the acute environment.</p>
Mental health intensive care	<p>When responding to a sexual safety risk or incident it is not appropriate to transfer the sexually at-risk consumer who has been harmed to an intensive care area (ICA). This must not occur except in exceptional circumstances, which should be clearly documented. Being transferred to a more restrictive area can be experienced as a ‘punishment’, causing further trauma. This practice may cause people to avoid reporting sexual safety incidents. Alternatives include:</p> <ul style="list-style-type: none"> • moving the alleged instigator to the ICA • using the women-only area • moving the sexually at-risk consumer to another floor • increasing nursing engagement • increasing leave entitlements • engaging family and carer support. <p>If moving the sexually vulnerable consumer to the ICA is unavoidable, take care to support their safety. The following actions should occur:</p> <ul style="list-style-type: none"> • Make sure the action is not experienced as punitive. • Include the consumer in decision making about how they can be and feel safe in this environment. • Consider the mix of consumers within the ICA. • Ensure appropriate staffing levels in the ICA. • Regularly review and update risk assessments and safety plans with the consumer. <p>Services must be working with the Department of Health to create gender-segregated ICA areas in line with recommendation 13 of the Royal Commission’s final report.¹¹ In the interim, if accommodating a female consumer in ICA following a sexual safety incident, consider making the ICA a women-only/gender-safe area for a period.</p>

2.2 Restrictive interventions

Restrictive interventions are disempowering and can destroy a person’s sense of autonomy and control over a situation. Part 3.1 of the Act outlines the decision-making principles that mental health and wellbeing services must give proper consideration when making decisions about restrictive interventions, including the principle that there is no therapeutic benefit to restrictive interventions.

¹¹ Royal Commission in Victoria’s Mental Health System – final report, 2021.

People subjected to restrictive interventions can experience feelings that mirror those that arise from sexual abuse, assault or another traumatic experience. Restrictive intervention use has been linked to re-traumatisation of past experiences or can be a cause of initial trauma.

To create an environment where consumers can feel and be sexually safe, reduce or eliminate the use of restrictive interventions. Also, 'post restrictive intervention consumer support' (a form of debriefing) must always occur and is especially important to employ if past sexual trauma has been triggered.

For more detailed information on restrictive interventions and complying with the Act, please refer to the [Chief Psychiatrist's interim guideline on Restrictive interventions](https://health.vic.gov.au/chief-psychiatrist/chief-psychiatrists-restrictive-interventions).
<<https://health.vic.gov.au/chief-psychiatrist/chief-psychiatrists-restrictive-interventions>>

2.3 Trauma-informed care

Deliver all practices and interventions described in this guideline, in relation to both preventing and responding to sexual safety incidents, in line with the principles of trauma-informed care. Under this guideline, services must:

- understand that sexual safety incidents can compound the impact of previous trauma
- assume all consumers have experienced trauma and consider how this affects their sexual safety
- recognise the prevalence, signs and impact of trauma, particularly in relation to sexual safety – for example, vulnerability to being sexually exploited or reluctance to disclose incidents
- understand that work practices or other aspects of mental health treatment, particularly compulsory treatment, and restrictive interventions, where there is a power imbalance or limitation of personal choice, can be re-traumatising
- acknowledge community-specific trauma (for example, cultural, historical, gender contexts) and its impact
- ensure everyone in a service feels and is emotionally, psychologically, physically and sexually safe
- support consumers with past trauma and provide trauma-specific care (including making appropriate referrals) when indicated
- ensure staff are involving family, carers and supporters in the care and treatment process
- ensure staff are appropriately trained to provide trauma-informed care to consumers about their sexual safety and have access to discipline-specific supervision to support this practice.

2.4 Supported decision making

The Act states that consumers are to be supported to make decisions and to be involved in decisions about their assessment, treatment and recovery (s 19). Supported decision making is particularly important in relation to both preventing and responding to sexual safety incidents.

- Support consumers to make decisions about their safety planning when entering a bed-based mental health service in relation to what will help them to be and feel sexually safe. Advance statement of preferences (s 57) may provide relevant information.
- Choice and control over decision making to make decisions following a sexual safety incident is extremely important. Experiences of trauma are often characterised by lack of control and disempowerment, and recovery from trauma can be assisted by ensuring victim-survivors have their autonomy restored when responding to incidents. There are, however, times when services need to report a sexual safety incident to the police without the consumer's consent. When this

occurs, support the person to access as much rights-based information as possible and present them with all advocacy options. Services should also provide the person with information about the service's decision to report the matter to the police (for more refer to [Part 5.1 Reporting to police](#) of this document).

- Access to rights-based information and advocacy services (for example, CASA) can provide substantial support to consumers who are making decisions about how to respond to a sexual safety incident.

2.5 Meeting individual sexual safety needs

Some individual characteristics or identities may shape a person's sexual safety needs and risks. Staff should aim to learn from consumers about how they can support individual needs. Consider the way that different aspects of a consumer's identity intersect and shape their experience.

The Act states that the diverse needs and experiences of a person receiving mental health and wellbeing services, including those attributable to their culture or gender, are to be actively considered (s 25). Mental health and wellbeing services are to be culturally safe and responsive to people of all racial, ethnic, faith-based and cultural backgrounds (s 27). The Act also states that mental health and wellbeing services must consider gender safety and provide services that are safe, responsive to experiences or history of family violence or trauma and respond to the ways that gender dynamics influence service delivery, treatment and recovery (s 26).

2.5.1 Meeting the needs of Aboriginal consumers

Based on crime data from the Australian Bureau of Statistics in 2016, Aboriginal Australians were up to 3.4 times more likely to be the victim of sexual assault than non-Aboriginal Australians.

Aboriginal cultures are the oldest living cultures in the world. Cultural factors, such as identity, language and spirituality, as well as connection to Country, to family and to community, can positively impact on the lives of Aboriginal people.

The Victorian Population Health Survey (2017) found that 47 per cent of Aboriginal people had experienced racism in health settings in the 12 months preceding the survey. In addition to overt racism, the day-to-day practices and policies of health services can be culturally unsafe for Aboriginal people. The Victorian Auditor-General's 2014 report [Accessibility of mainstream services for Aboriginal Victorians](#) <<https://www.audit.vic.gov.au/sites/default/files/20140529-Aboriginal-Services.pdf>> identified lack of cultural safety as a significant barrier to accessing services.

Cultural rights are a fundamental human right (section 19 of the [Charter of Rights and Responsibilities Act 2006](#) (Vic)) <<https://www.legislation.vic.gov.au/in-force/acts/charter-human-rights-and-responsibilities-act-2006/015>>. Public agencies are required by law to provide safety in the workplace. A culturally safe environment for Aboriginal consumers is one that is safe for Aboriginal people, where there is no assault, challenge or denial of their identity and experience.

Services must be culturally safe for Aboriginal consumers and their families, carers and communities. Services are referred to *Koolin Balit* and the *National strategic framework for Aboriginal and Torres Strait Islander peoples' mental health and social and emotional wellbeing*.

The Act states that regard is to be given to Aboriginal and Torres Strait Islander people's unique culture and identity, including connections to family and kinship, community, Country and waters (s 27(2)). Treatment and care for Aboriginal and Torres Strait Islander peoples is, to the extent that it is practicable and appropriate to do so, to be decided and given having regard to the views of elders, traditional healers and Aboriginal and Torres Strait Islander mental health workers (s 27(3)).

Consider the following when supporting the sexual safety of Aboriginal consumers in mental health and wellbeing services:

- Victorian Aboriginal communities are resilient, strong and rich in their culture. However, colonisation, racism, discrimination and transgenerational trauma continue to have an impact on Aboriginal health, and social and emotional wellbeing. It is critical that service providers respond to sexual safety concerns in a way that does not perpetuate these structural inequalities.
- It is vital that Aboriginal consumers can speak with a staff member who is the same gender as them when discussing matters to do with sex, sexuality or sexual safety. For example, Aboriginal women in many instances will only be willing to speak to another woman due to cultural protocols. These cultural protocols also apply for men, who are more likely to want to speak to another man.
- Aboriginal women are at higher risk of being victims of family violence, and this may impact on their sexual safety.
- Where appropriate and available, give Aboriginal consumers the opportunity to engage with local Aboriginal community-led services and Aboriginal staff.
- Aboriginal self-determination, and Aboriginal concepts of health and social and emotional wellbeing, should be respected, upheld and at the forefront of decision making when addressing sexual safety concerns.
- Aboriginal-specific supports include:
 - [Dijirra](https://djirra.org.au/) <https://djirra.org.au/>
 - [Victorian Aboriginal Health Service](https://www.vahs.org.au/) <https://www.vahs.org.au/>
 - [Boorndawan Willam Aboriginal Healing Service](http://bwahs.com.au/) <http://bwahs.com.au/>
 - Yarning Safe and Strong – Free and confidential counselling service for Aboriginal people phone: 1800 959 563, email: ysns@vahs.org.au.

2.5.2 Culturally diverse consumers

Be conscious of the different sexual safety needs of consumers based on their cultural, linguistic or religious background or beliefs. Considerations include:

- cultural expectations around people of different genders being accommodated together
- potential family consequences for consumers who are involved in sexual safety incidents (this consideration should be part of the decision making around informing families, carers and supporters of sexual safety incidents without the consumer's consent)
- culturally safe ways to engage with consumers around sex and sexuality to support sex education and to provide information about service expectations
- how a person's cultural background may intersect with other aspects of their identity – for example, sexuality
- the possible trauma history of people from refugee backgrounds and how this may impact on their experience of care
- the communication needs of culturally diverse consumers and their families, carers and supporters, arrange interpreters if required.

2.5.3 LGBTIQ+ consumers

The Act's diversity principle states that mental health and wellbeing services are to actively consider the diverse needs and experiences of consumers, including in relation to gender identity and sexual orientation (s 25).

The needs of LGBTIQ+ consumers and their families, carers, and supporters must be considered in relation to sexual safety.

- Support consumers' identities by using inclusive language and correct pronouns (for example, he/him, she/her, they/them).
- Accommodate consumers appropriately (for example, in the women-only/gender-safe area) according to their identity, preference and risk assessment.
- Staff must be sensitive to consumers whose gender identity or body does not match society's expectations. This includes being particularly conscious of privacy, and considerate when undertaking procedures such as a medical review.
- Staff must be conscious that some consumers may not wish to out themselves in relation to their sex, gender identity or sexuality in certain circumstances and respect these choices.
- Services must consider the needs of consumers who may be going through a gender transition and consider the impact of treatments such as hormone therapies.
- Services must take an inclusive approach to family and be aware that for some LGBTIQ+ consumers their identity may be a source of conflict in relationships with their family of origin. Acknowledging and including consumers' family of choice is particularly important for this cohort.

3. Promoting sexual safety and preventing incidents

3.1 Governance, leadership and workforce capability

For more information refer to:

- [Safer Care Victoria: Delivering high-quality healthcare – Victorian clinical governance framework](https://www.bettersafecare.vic.gov.au/publications/clinical-governance-framework) <<https://www.bettersafecare.vic.gov.au/publications/clinical-governance-framework>>.

3.1.1 Governance

Establish and maintain governance structures for promoting sexual safety. Incorporate a multidisciplinary approach, including lived and living experience workers from both a consumer and family and carer perspective, into all governance structures. Leadership at all levels is important in establishing a culture that prioritises the sexual safety of people accessing mental health and wellbeing services.

The scope and aims of sexual safety governance arrangements include:

- promoting the rights of those consumers and continuous improvement in relation to sexual safety in mental health and wellbeing services
- ensuring and monitoring that staff are clear about their roles and responsibilities associated with promoting sexual safety and are supported in their roles with appropriate resources
- ensuring that legislative and reporting requirements are met, for example, reporting to the Chief Psychiatrist or ensuring that services are aligned with the gender safety principle of the Act (s 26)
- using data to actively identify, monitor and manage areas of key risk
- engaging with the Department of Health and the Mental Health and Wellbeing Division's strategies for eliminating gender-based and sexual violence in bed-based services.

3.1.2 Workforce capability

Services must ensure all staff have the required capability to practice in line with this guideline.

The [Victorian mental health and wellbeing workforce capability framework \(2021\)](https://www.health.vic.gov.au/publications/mental-health-workforce-strategy)

<<https://www.health.vic.gov.au/publications/mental-health-workforce-strategy>> outlines the 15 capabilities that should be present across the mental health and wellbeing workforce. This includes a number of capabilities with direct relevance to sexual safety:

- embedding responsible, safe and ethical practice
- understanding and responding to trauma
- working effectively with families, carers and supporters
- delivering compassionate treatment, care and support.

Consider the training and education needs of all staff, including lived experience workers. Consider engaging specialist services such as local CASAs to help develop workforce capability. Consider how other training – for example, training around trauma-informed care – may be applied in this context.

Given the values-based nature of sex and sexual safety, staff may have their own beliefs and attitudes, but it is important that this does not impact on how they interpret and respond to incidents. All staff must be able to respond in a way that is compassionate. Staff development should have a strong focus on core principles of supporting and responding to sexual safety.

3.2 Standards for maintaining a safe environment

The Royal Commission into Victoria's Mental Health System recommended that the Victorian Government supports mental health and wellbeing services to eliminate sexual and gender-based violence in bed-based settings (recommendation 13).

The Act states that people receiving mental health and wellbeing services may have specific safety needs or concerns based on their gender (s 26). Under the Act, consideration of these needs and concerns is to be given and access is to be provided to services that:

- are safe (s 26(a))
- respond to experiences or history of family violence or trauma (s 26(b))
- recognise and respond to the ways gender dynamics may affect service delivery, treatment and recovery (s 26(c))
- recognise and respond to the ways in which gender intersects with other types of discrimination and disadvantage (s 26(d)).

3.2.1 Physical environments to support safety

Features in the physical environment can improve the experience of safety. Consider, for example, gender-based separation. [The Royal Commission's final report \(recommendation 13\)](https://finalreport.rcvmhs.vic.gov.au/wp-content/uploads/2021/02/RCVMHS_FinalReport_ExecSummary_Accessible.pdf)

<[https://finalreport.rcvmhs.vic.gov.au/wp-](https://finalreport.rcvmhs.vic.gov.au/wp-content/uploads/2021/02/RCVMHS_FinalReport_ExecSummary_Accessible.pdf)

[content/uploads/2021/02/RCVMHS_FinalReport_ExecSummary_Accessible.pdf](https://finalreport.rcvmhs.vic.gov.au/wp-content/uploads/2021/02/RCVMHS_FinalReport_ExecSummary_Accessible.pdf)> states that:

- New bed-based services must be built with the necessary scale and flexible infrastructure to enable gender-based separation in all bedrooms and bathrooms, and separate communal spaces (ideally inclusive of outdoor spaces) as required.
- By mid-2022 all high dependency units in inpatient facilities must allow for gender-based separation.

- Existing services must be reviewed and retrofitted on a case-by-case basis to achieve gender-based separation and meet minimum standards for gender safety.

Services must comply with these recommendations.

In addition to the Royal Commission's recommendations, there are features of the built environment that support sexual safety in bed-based services. Health services should pursue building upgrades if necessary to prioritise the following facility features:

- women-only/gender-safe areas for bedrooms and common areas
- consumer-controlled, lockable bedrooms and bathrooms across all areas (from the inside and outside)
- providing male, female, and gender-neutral bathrooms in shared areas
- areas that can be used flexibly (flex or swing-beds)
- safe visiting areas for families, carers and supporters
- fittings, such as window coverings, to ensure consumers' privacy
- movement sensors in common areas
- sufficient lighting in all areas
- access to duress alarms for consumers.

In addition, as soon as practicable services should move towards:

- providing individual rooms with ensuite bathrooms
- eliminating blind spots
- ensuring the design enables flexible use of space to support safety and enable a response to diverse consumers who may be vulnerable for a variety of reasons.

Gender-safe areas

Cisgender men (excluding staff) should not have access to women-only/gender-safe areas at any time. This includes consumers and visitors. Support safety for women by having swipe access (or similar) to these areas. Trans women, trans men or otherwise gender diverse consumers may be accommodated in women-only/gender-safe areas as appropriate. Base bed allocation decisions on:

- a discussion with consumers about their safety
- an assessment of the area best able to support their physical and psychological safety
- consumer preference
- a risk assessment, including collateral information from families, carers and supporters.

Where available, flexible areas (flex or swing-beds) can be used to accommodate vulnerable consumers who cannot be, or do not wish to be, accommodated in the women-only/gender-safe area. These areas can also be used to ensure services can respond to bed pressures while still maintaining women-only/gender-safe areas.

Practice to support safe physical environments

Staff practice and processes must support the safety of the physical environment. For example, practice around re-locking bedroom doors following visual observations is essential. Also, local policies can support the safety of the physical environment, and staff should uphold these practices. In acute inpatient units, SECUs and PARCs consumers **must not** be allowed in another consumer's bedroom.

Safety features, such as movement sensors, must support nursing practice and must not replace nursing presence throughout the ward and regular observations.

3.3 Communicating about sexual safety

3.3.1 Orientation to bed-based services

Provide information about sexual safety to consumers and families, carers and supporters as part of their orientation to a bed-based service. In most settings, including acute inpatient services, PARCs and SECUs, this must include informing consumers that sexual activity is not permitted. Explain the rationale for this. This can help to prevent sexual safety incidents.

Discussions about sexual safety can also provide an opportunity to create a safe, welcoming space and to start developing a therapeutic relationship. Staff need to be sensitive and thoughtful in these conversations because the topic may be distressing or alarming. Sexual safety orientation can:

- encourage help-seeking
- initiate conversations about what would help consumers to feel safe
- establish that consumers can express sexual safety concerns
- increase consumers' confidence to disclose incidents if they occur.

There are several considerations when delivering sexual safety orientation:

- Orientation should be in the form of a conversation and provide consumers and families, carers and supporters with the opportunity to raise their own concerns and identify strategies that may help them to be and feel safe. Staff should explain frequently used strategies – for example, using women-only/gender-safe areas.
- Follow up conversations should occur with written information when appropriate.
- Orientation should occur as close to the time of entry into a service as possible but must consider the consumer's ability to take on information at that time. In some services – for example, PARCs, this may occur during a preadmission visit.
- If orientation cannot occur at the point entry into a service – for example, due to mental state – make and document clear plans for when and how to deliver this information.
- Regularly revisit orientation information during the consumer's stay at a bed-based service.

3.3.2 Sexual education for consumers

Provide and discuss sexual health, safety and creating a sexually safe environment as a normal part of recovery-oriented practice. Consider this in all bed-based services. However, the opportunities in different bed-based settings may vary depending on factors such as the level of acuity and length of stay.

Sexual education can occur through:

- Staff and consumer meetings (for example, mutual help meetings – refer to [Safewards](https://www2.health.vic.gov.au/-/media/health/files/collections/policies-and-guidelines/s/safewards-victoria-handbook-2016.pdf) information <<https://www2.health.vic.gov.au/-/media/health/files/collections/policies-and-guidelines/s/safewards-victoria-handbook-2016.pdf>>)
- posters in toilets and bedrooms or other written material (with opportunities to have the material explained verbally)
- discussion of sexuality, safe sex practices, sexual safety, consent and relationships in case management or key-worker meetings, medical reviews and so on
- continual discourse between staff and consumers outside formal scenarios, as needed (for example, when the topic is raised by a consumer, when sexual vulnerability or other risks are identified).

Ensure sexual education is inclusive. Tailor it to the individual needs of consumers, including being considerate of LGBTIQ+ needs and appropriate to different cultural attitudes towards sex.

3.3.3 Communication with families, carers and supporters

Mental health and wellbeing services have a responsibility to ensure that families and carers are supported in their role in decisions about the person's assessment, treatment, and recovery (s 20). Information should be shared with families, carers and supporters in line with the consumer's preference and the information sharing principles outlined under the Act (Part 17.1). Information sharing must not compromise the dignity of the consumer, information should be shared in a way that is accessible, and consideration should be given to how information sharing supports family, carers and supporters fulfil their role in relation to the person.

If sharing information may increase the risk of a consumer being subjected to family violence mental health and wellbeing services must not share information, even with the consumers consent (s 31). For practice guidance regarding family violence see [MARAM practice guides and resources](https://www.vic.gov.au/maram-practice-guides-and-resources) <<https://www.vic.gov.au/maram-practice-guides-and-resources>>.

Communicating with families throughout the admission can increase the capacity of families, carers and supporters to recognise and respond to risks. Provide families, carers and supporters with orientation information that includes:

- information about sexual safety
- what the expectations are
- how services support safety.

Families, carers and supporters should also be informed about how they can communicate with the service about this information.

For more, refer to [Chief Psychiatrist guideline: Working together with families and carers](https://www.health.vic.gov.au/chief-psychiatrist/working-together-with-families-and-carers) <<https://www.health.vic.gov.au/chief-psychiatrist/working-together-with-families-and-carers>>.

3.4 Safety planning for sexual safety

Safety planning, or risk assessment, is a fundamental part of preventing and responding to sexual safety incidents.

In this context it is especially important that safety planning is conducted in collaboration with the consumer and involves family, carers and supporters. Employ the principle of supported decision making (s 19).

Safety planning for sexual safety occurs at different points of a consumer's stay in a bed-based service including as part of the orientation to the service and at any time that a change to sexual safety risk is identified. Safety planning is to include:

- collaborating with consumers to identify what will help the consumer to be and feel safe
- considering appropriate bed allocation (for example, in women-only/gender-safe areas, close to the nurses' station)
- asking the consumer what will help them behave in sexually safe ways
- conversations about sexual safety harm reduction. Sexual harms can result from sexual activity. Consumers have the right to access condoms and other contraception. Include a discussion about the inappropriateness of sexual activity in the service.

- conversations about safety when the consumer is on leave or is discharged. These conversations should include a discussion about safe relationships and consent.

Appendix 1: Interpersonal responses to sexual safety incidents

The following interpersonal responses were developed by the Victorian Mental Health Interprofessional Leadership Network (2019), which was led and informed by people with a lived experience.

Response	Delivery
Acknowledge and listen	Acknowledgment, rather than avoidance, should be the response to the consumer's disclosure of a sexual safety incident.
Believe the consumer	Believe the consumer on their first disclosure of a sexual safety incident. Staff should validate the consumer's experience with their initial reaction.
Avoid assumptions and stereotypes	Listen attentively to the details of the disclosure without making assumptions or applying stereotypes. Put these assumptions aside and respond without bias.
Avoid minimising	Give all disclosures the same weight and significance and respond to each with the same rigour.
Respectful response	Respond without frustration, judgement, blame, shaming, anger or aggression.
Empathetic response	Empathise with the consumer's perspective and reactions to the disclosed incident. Consider the perspective of all parties, including the alleged perpetrator (whether consumer, staff or visitor).
Immediate support	Be immediately responsive to disclosures and prioritise the required support over other duties.
Measured response	Despite the need for immediacy, the response should be measured, confidently following all necessary steps without catastrophising. Listen attentively to the disclosure in full and apply interpersonal responses before escalating to senior staff.
Reassure and check in	Reassure the consumer that they have done nothing wrong and that their needs will be met, and safety and security ensured. Regularly check in with the consumer during the responding process.
No excuses for other party	Avoid making excuses for the other party's behaviour when speaking to the victim-survivor.
Transparency	Be transparent with consumers about the unit's responding process and possible police processes. Provide information in an honest and open way. Communicate in a way that does not cause anxiety or distress (for example, not swaying the victim-survivor away from reporting to police).
Understand communication difficulties	Express understanding that the consumer may have difficulties remembering details or articulating the incident. This may be the case after a traumatic event and does not mean the incident did not occur.
Understand diversity issues	Recognise the diversity of every individual and modify approaches to consumer disclosures to accord with different perspectives and needs.
Use correct pronouns	Ask for preferred pronouns and use these consistently. It may be useful for staff to first state their preferred pronouns. This is necessary practice but also interpersonally conveys respect, recognition and inclusivity.
Use soft words	Refer to and apply the Safewards (2016) 'soft words' intervention, which gives guidance on language and interpersonal approaches to consumers.

Appendix 2: Responding to sexual safety incidents

Considerations	Have the following prompts been considered when responding to sexual safety incidents?
Re-establishing safety	<ul style="list-style-type: none"> Has everyone been supported to move to a safe location? Has psychological support and validation been offered? Who is best situated to provide this support? Have Safewards <https://www2.health.vic.gov.au/safewards> strategies (for example, 'defusing' or 'soft words') been used?
Safety planning	<ul style="list-style-type: none"> Have involved parties had the opportunity to identify what would support their safety going forward? Do any of the parties need to be relocated (for example, moved to another ward or discharged home) to ensure safety for all? Do nursing observations and risk assessments need to be reviewed?
Providing care following an incident	<ul style="list-style-type: none"> Is a medical examination indicated and does the person consent? Do you need to seek advice from Victorian Institute of Forensic Medicine (VIFM) <https://www.vifm.org/>? Does a psychiatric review need to be arranged?
Advocacy and support	<ul style="list-style-type: none"> Have all parties have had the opportunity to be supported to make decisions that affect them? Have you informed the affected person about the support available from Centre Against Sexual Assault (CASA) <https://www.casa.org.au/> or Sexual Assault Crisis Line (SACL) <https://www.sacl.com.au/> and offered to make a referral? Have you offered legal and non-legal advocacy options to all parties (for example, Mental Health Legal Centre <https://mhc.org.au/>, Mental Health and Wellbeing Commission (MHWC) <https://www.mhwc.vic.gov.au/> or Victoria Legal Aid <https://www.legalaid.vic.gov.au/>)? Could Lived Experience staff be engaged to support accessing advocacy services?
Communication	<ul style="list-style-type: none"> Have you contacted the relevant family member, carer or supporter? Can the consumer make this contact themselves? How can you support this process? If consumers do not wish to inform family, a carer or a supporter, have you considered whether you are obliged to contact without consent (for example, if there a nominated person or an ongoing risk)? Could sharing this information cause a risk (for example, family violence, cultural norms)? Will an open disclosure process be required or does the incident meet the criteria for a Serious Adverse Patient Safety Event (SAPSE) <https://www.safercare.vic.gov.au/sites/default/files/2022-10/Victorian%20Duty%20of%20Candour%20Guidelines%20-%20FINAL.docx>? Has information about the incident been included in the discharge summary? Has recovery oriented, culturally safe language been used? NSW Mental Health Coordinating Council's Recovery oriented language guide <http://www.mhcc.org.au/wp-content/uploads/2019/08/Recovery-Oriented-Language-Guide_2019ed_v1_20190809-Web.pdf> LGBTIQ inclusive language guide <https://www.vic.gov.au/inclusive-language-guide>
Reporting	<ul style="list-style-type: none"> Has the incident been reported via RiskMan? Has the incident been thoroughly and accurately documented in all relevant medical records? Department of Health – Measuring mental health outcomes – documentation <https://www2.health.vic.gov.au/mental-health/practice-and-service-quality/service-quality/measuring-outcomes-in-mental-health/measuring-outcomes-documentation>. Has the matter been escalated within the service in line with local protocols (for example, site manager, on-call consultant, nurse unit manager, after-hours manager)? Do you need to report the incident to the Office of the Chief Psychiatrist?
Victoria Police	<ul style="list-style-type: none"> Does the affected person want to report the matter to the police? Does the service have a responsibility to report the matter to the police, even without consent? How can the affected person be supported to make the report to police? Have you contacted the police for advice? Refer also to the Victoria Police Reporting sexual offences booklet <https://www.police.vic.gov.au/resources-and-fact-sheets-0#reporting-sexual-offences-booklet>. Victoria Police Code of conduct – professional and ethical standards <https://www.chiefexaminer.vic.gov.au/content.asp?a=internetBridgingPage&Media_ID=53208>
Supporting staff	<ul style="list-style-type: none"> Have staff involved been offered support? Are affected staff members able to finish their shift? Has how and when the staff group will be debriefed been considered?

References and resources

Resource links from the guideline

[1800 My Options](http://www.1800myoptions.org.au) <http://www.1800myoptions.org.au>

[Australasian health facility guidelines](https://healthfacilityguidelines.com.au) <https://healthfacilityguidelines.com.au>

[CASA – Information for survivors and friends](https://www.casa.org.au/survivors-and-friends/) <https://www.casa.org.au/survivors-and-friends/>

[Chief Psychiatrist's interim guidance: Decision making principles for treatment and interventions](https://www.health.vic.gov.au/chief-psychiatrist/decision-making-principles-for-treatment-and-interventions-mental-health-and-wellbeing-act-2022) <https://www.health.vic.gov.au/chief-psychiatrist/decision-making-principles-for-treatment-and-interventions-mental-health-and-wellbeing-act-2022>

[Chief Psychiatrist's guideline – Inpatient leave of absence \(2018\)](https://www.health.vic.gov.au/chief-psychiatrist-guidelines/inpatient-leave-of-absence) <https://www.health.vic.gov.au/chief-psychiatrist-guidelines/inpatient-leave-of-absence>

[Chief Psychiatrist's guideline: Restrictive interventions](https://www.health.vic.gov.au/chief-psychiatrist/chief-psychiatrists-restrictive-interventions) <https://www.health.vic.gov.au/chief-psychiatrist/chief-psychiatrists-restrictive-interventions>

[Chief Psychiatrist's Reporting Directive - Sexual safety incidents \(2023\)](https://www.health.vic.gov.au/chief-psychiatrist/improving-sexual-safety) <https://www.health.vic.gov.au/chief-psychiatrist/improving-sexual-safety>

[Chief Psychiatrist's guideline – Working together with families and carers \(2018\)](https://www.health.vic.gov.au/chief-psychiatrist/working-together-with-families-and-carers) <https://www.health.vic.gov.au/chief-psychiatrist/working-together-with-families-and-carers>

[Department of Health – Open disclosure](https://www.health.vic.gov.au/quality-safety-service/open-disclosure-framework) <https://www.health.vic.gov.au/quality-safety-service/open-disclosure-framework>

[LGBTIQ inclusive language guide](https://www.vic.gov.au/inclusive-language-guide) <https://www.vic.gov.au/inclusive-language-guide>

[Mental Health Complaints Commission \(2018\) - The right to be safe: ensuring sexual safety in mental health acute inpatient units](https://www.mhwc.vic.gov.au/right-be-safe-sexual-safety-project-report) <https://www.mhwc.vic.gov.au/right-be-safe-sexual-safety-project-report>

[Mental Health Coordinating Council – Recovery-oriented language guide](http://www.mhcc.org.au/wp-content/uploads/2019/08/Recovery-Oriented-Language-Guide_2019ed_v1_20190809-Web.pdf) <http://www.mhcc.org.au/wp-content/uploads/2019/08/Recovery-Oriented-Language-Guide_2019ed_v1_20190809-Web.pdf>

[Office of the Chief Mental Health Nurse – Mental health intensive care framework \(2019\)](https://www.health.vic.gov.au/publications/mental-health-intensive-care-framework) <https://www.health.vic.gov.au/publications/mental-health-intensive-care-framework>

[Office of the Chief Mental Health Nurse – Safewards handbook](https://www.health.vic.gov.au/practice-and-service-quality/safewards-training-resources) <https://www.health.vic.gov.au/practice-and-service-quality/safewards-training-resources>

[Protecting Children Protocol between Department of Human Services – Child Protection and Victoria Police](https://www.dhhs.vic.gov.au/sites/default/files/documents/201706/Protecting-Children-CP-and-VicPol-protocol-2012.pdf) <https://www.dhhs.vic.gov.au/sites/default/files/documents/201706/Protecting-Children-CP-and-VicPol-protocol-2012.pdf>

[Sexual Assault Crisis Line](https://www.sacl.com.au/frequently-asked-questions/) <https://www.sacl.com.au/frequently-asked-questions/>

[Sexual assault services throughout Victoria that attend to child and youth](https://services.dffh.vic.gov.au/sexual-assault-support-services) <https://services.dffh.vic.gov.au/sexual-assault-support-services>

[Victoria Legal Aid](https://www.legalaid.vic.gov.au/) <https://www.legalaid.vic.gov.au/>

[Victoria Police – Code of conduct](https://www.chiefexaminer.vic.gov.au/chief-examiner) <https://www.chiefexaminer.vic.gov.au/chief-examiner>

[Victoria Police – Reporting sexual offences booklet](https://www.police.vic.gov.au/reporting-sexual-offences-child-abuse#reporting-sexual-offences-booklet) <https://www.police.vic.gov.au/reporting-sexual-offences-child-abuse#reporting-sexual-offences-booklet>

[Victorian Forensic Paediatric Medical Service \(VFPMS\)](https://www.rch.org.au/vfpms/) <https://www.rch.org.au/vfpms/>

[Victorian Institute of Forensic Medicine \(VIFM\)](https://www.vifm.org/) <https://www.vifm.org/>

Contacts

[CASA \(statewide\)](https://casa.org.au/contact-us/) <https://casa.org.au/contact-us/>

[Mental Health Legal Centre](https://mhlc.org.au/) <https://mhlc.org.au/>; phone (03) 9629 4422

[Melbourne Sexual Health Centre](https://www.mshc.org.au) <https://www.mshc.org.au> >; phone (03) 9341 6200

[Sexual Assault Crisis Line](https://www.sacl.com.au/) <https://www.sacl.com.au/>; phone 1800 806 292

[Victorian Forensic Paediatric Medical Service \(VFPMS\)](https://www.rch.org.au/vfpms/) <https://www.rch.org.au/vfpms/>; phone 1300 661 142

[Victorian Institute of Forensic Medicine \(VIFM\)](https://www.vifm.org/) <https://www.vifm.org/>; phone (03) 9684 4480 <https://www.vifm.org/>

Legislation and conventions

[Charter of Human Rights and Responsibilities Act 2006 \(Vic\)](http://classic.austlii.edu.au/au/legis/vic/consol_act/cohrara2006433/) <http://classic.austlii.edu.au/au/legis/vic/consol_act/cohrara2006433/>

[Children, Youth and Families Act 2005 \(Vic\)](http://classic.austlii.edu.au/au/legis/vic/consol_act/cyafa2005252/) <http://classic.austlii.edu.au/au/legis/vic/consol_act/cyafa2005252/>

[Crimes Act 1958 \(Vic\)](http://classic.austlii.edu.au/au/legis/vic/consol_act/ca195882/). <http://classic.austlii.edu.au/au/legis/vic/consol_act/ca195882/>

[Mental Health and Wellbeing Act 2022 \(Vic\)](https://www.legislation.vic.gov.au/in-force/acts/mental-health-and-wellbeing-act-2022/001) < https://www.legislation.vic.gov.au/in-force/acts/mental-health-and-wellbeing-act-2022/001>

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Policies, reports and resources

Ahpra and National Boards. (2020). [Guidelines: Mandatory notifications about registered health practitioners](https://www.ahpra.gov.au/Notifications/mandatorynotifications/Revised-guidelines.aspx) <https://www.ahpra.gov.au/Notifications/mandatorynotifications/Revised-guidelines.aspx>

Mental Health Complaints Commission (2018) - [The right to be safe: ensuring sexual safety in mental health acute inpatient units](https://www.mhwc.vic.gov.au/right-be-safe-sexual-safety-project-report) <https://www.mhwc.vic.gov.au/right-be-safe-sexual-safety-project-report>

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[Royal Commission final report – Volume 2, Chapter 15 – Responding to trauma](https://finalreport.rcvmhs.vic.gov.au/wp-content/uploads/2021/02/RCVMHS_FinalReport_Vol2_Accessible.pdf) <https://finalreport.rcvmhs.vic.gov.au/wp-content/uploads/2021/02/RCVMHS_FinalReport_Vol2_Accessible.pdf>.

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State of Victoria, Department of Health and Human Services. (2018a). [Chief Psychiatrists guideline - Working together with families and carers](https://www2.health.vic.gov.au/about/key-staff/chief-psychiatrist/chief-psychiatrist-guidelines/working-together-with-families-and-carers) <<https://www2.health.vic.gov.au/about/key-staff/chief-psychiatrist/chief-psychiatrist-guidelines/working-together-with-families-and-carers>>

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Victoria Police. (2020). [Reporting sexual offences to police](https://www.police.vic.gov.au/resources-and-fact-sheets-0) [booklet]. <<https://www.police.vic.gov.au/resources-and-fact-sheets-0>>