Sexual health and safety in mental health alcohol and other drugs services

Queensland Health (Statewide) Guideline

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An electronic version of this document is available at https://www.health.qld.gov.au/system-governance/policies-standards/guidelines.

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Contents

Acknowledgements

Acknowledgement of Traditional Owners

Queensland Health respectfully acknowledges the Traditional Owners and Cultural Custodians of the lands, waters and seas across Queensland. We pay our respects to Elders past and present, and recognise the role of current and future leaders in shaping a better health system.

We value the culture, traditions, and contributions that Aboriginal and Torres Strait Islander peoples have made to our communities, and recognise that our collective responsibility as government, communities and individuals is to ensure equity and equality, recognition, and advancement of Aboriginal and Torres Strait Islander peoples in Queensland in every aspect of our society.

Recognition of lived experience

We recognise those with a lived experience of sexual assault, harassment, abuse or technology-facilitated abuse (sexual violence) and the associated trauma experienced by individuals, families and communities. We recognise their journey navigating services and systems, and their resilience, resourcefulness and strength in the face of adversity.

Workforce recognition

We recognise the professionalism and commitment of the mental health, alcohol and other drugs workforce. We thank them for their concerted efforts to support safe care and improved outcomes for all Queenslanders.

Acknowledgement of content

This guideline includes content adapted, with permission, from Victoria's 2025 Chief Psychiatrist guideline *Improving Sexual Safety in Mental Health and Wellbeing Services*.

A note about language

Queensland Health recognises that people who access mental health alcohol and other drugs services and people who have experienced sexual violence may prefer certain terms to describe themselves. This document uses the following terms:

- 'Consumer' to indicate a person who is receiving or seeking care from public mental health and/or alcohol and other drugs services.
- 'Affected consumer', 'affected person' and 'victim-survivor' to indicate a consumer who has disclosed, alleged or reported a sexual safety incident, or who is otherwise suspected or known to have experienced a sexual safety incident.

Queensland Health recognises and respects that consumer preference should guide the use of person-first language (e.g. person with disability) and identity-first language (e.g. autistic person) in the provision of care. It is recognised that language conventions may change over time as community views and standards evolve.

Definitions of key terms can be found in the Glossary at the back of the document.

Purpose

Everyone has a right to sexual and reproductive health and sexual safety [1]. Health services are required through legislation, service directives and national standards (and expected through duty of care) to provide service settings that are safe; prevent breaches of sexual safety; and respond appropriately when incidents occur that affect a consumer's sexual safety.

This guideline sets out the relevant legislation and policy, and outlines responsibilities for mental health alcohol and other drugs (MHAOD) services with regards to:

- supporting the sexual safety of people accessing MHAOD services
- identifying and addressing sexual safety risks
- providing sexually safe environments within MHAOD service settings
- responding to sexual safety incidents
- reporting sexual safety incidents
- supporting sexual and reproductive health care
- supporting human rights.

In circumstances where an individual's needs warrant a significant variation from this guideline, discussion with the consultant psychiatrist, nursing director or team manager is recommended, and if required the clinical director. The clinical reasoning behind the decision should be documented in the consumer's clinical record.

A one-page prompt sheet for staff who are responding to sexual safety incidents is at Section 20, Prompt Sheet 1.

A prompt sheet with considerations for a range of diverse consumer populations is at section 20, Prompt sheet 2.

1 Scope

This guideline is intended for use in all Queensland public MHAOD services, across all settings and all age groups.

Services are to ensure local governance processes and procedures are in place to support service responsibilities for sexual health and sexual safety. Local procedures should:

- align with this guideline
- align with sexual assault clinical pathways for the Hospital and Health Service (HHS) - refer to the Queensland Health Service Directive: Caring for people disclosing sexual assault
- be evidence-based, taking into account the setting and availability of local support services

- be developed and reviewed in consultation with consumers, families, carers and partnering service providers.

In relevant HHSs, there is a requirement to accept care and commence an approved Clinical Care Pathway within 10 minutes of the disclosure or presentation, for any person who:

- attends an Emergency Department and discloses having experienced sexual assault, or
- is presented by an officer of the Queensland Police Service as a victim of a sexual assault.

Refer to the Ministerial Direction – Crisis Care Process QH-MD-001.

This guideline does not comprehensively address the sexual safety of staff. For information on staff sexual safety, refer to:

- Human Resources Policy E5 - Preventing and responding to workplace sexual harassment and other unlawful sexual conduct
- Public Sector Commission Directive 02/25 Preventing and responding to sexual harassment and related conduct at work
- Managing the risk of psychosocial hazards at work - Code of Practice 2022.

2 Related documents

Queensland Legislation

- *Human Rights Act 2019*
- *Mental Health Act 2016*
- *Criminal Code Act 1899*
- *Anti-Discrimination Act 1991*
- *Child Protection Act 1999*
- *Domestic and Family Violence Protection Act 2012*
- *Public Health Act 2005*
- *Hospital and Health Boards Act 2011*
- *Information Privacy Act 2009*
- *Workplace Health and Safety Act 2011*
- Health Practitioner Regulation National Law (Queensland)

Policy, directives and standards

- National Safety and Quality Health Service Standards (2nd ed., 2021)
- Ministerial Direction QH-MD-001 – Crisis Care Process (2023)

- Queensland Health Service Directive QH-HSD-051 – Caring for people disclosing sexual assault (2024)
- Chief Psychiatrist Policies and Guidelines under the *Mental Health Act 2016*

Supporting documents/guidelines/frameworks

- Prevent. Support. Believe. Queensland's Framework to address Sexual Violence (2019) and associated Second Action Plan 2023-24 – 2027-28
- Queensland Safety Priorities in Mental Health Alcohol and Other Drugs Care (2024)
- Queensland Government Interagency Guidelines for responding to children, young people and adults who have experienced sexual assault or child sexual abuse (2023)
- Guideline for the management of care for people 14 years and over disclosing sexual assault (2023)
- Queensland Health paediatric forensic medical examination protocols (children and young adolescents)
- Queensland Health Sexual Assault Services Framework (2024)
- Queensland Sexual Health Framework (2022) and associated action plans for blood-borne viruses and sexually transmitted infections
- Assessing and responding to violence framework in mental health alcohol and other drugs services (formerly Violence Risk Assessment and Management Framework)
- Queensland Health Guide to Informed Decision-Making in Health Care (2025)
- Queensland Health Open Disclosure Guide (2020)
- Queensland Health Service Directive Guideline for Clinical Incident Management (2024)
- Queensland Health Guideline: Reporting Concerns of Child Abuse and Neglect to Child Safety and Sexual Offences against Children to the Police (2015)
- Making Tracks Together - Queensland's Aboriginal and Torres Strait Islander Health Equity Framework (2021) and associated HHS Health Equity Strategies
- Queensland Domestic and Family Violence Prevention Strategy 2016-2026
- Domestic and Family Violence Information Sharing Guidelines (2023)
- Aboriginal and Torres Strait Islander Patient care guideline (2014)
- Aboriginal and Torres Strait Islander adolescent sexual health guideline (2013)
- Code of Conduct for the Queensland Public Service (2011)
- National Code of Conduct for Health Care Workers (Queensland, 2015)
- Royal Australian and New Zealand College of Psychiatrists – Position Statement 113 - Sexual safety in mental health services in Australia and New Zealand
- Royal Australian and New Zealand College of Psychiatrists – Position Statement 100 – Trauma informed practice
- Memorandum of Understanding – Queensland Health and Queensland Police Service – Mental Health Collaboration (2017) *under review*

- Information sharing agreement between Queensland Health and Corrective Services – Disclosure of confidential information

3 Principles

1. Everyone has a right to sexual safety (consumers, family, carers, staff and visitors).
2. The safety, and physical and psychological needs of consumers are of paramount consideration.
3. MHAOD services give due consideration to human rights in all decisions related to treatment and care.
4. All consumers have a right to be treated with respect and dignity, and to receive services free from abuse, exploitation, discrimination, coercion, harassment and neglect.
5. Consumers have a right to participate in decisions about their treatment and care. Informed and supported decision-making is prioritised and respected at all times.
6. Consumers' sense of personal control is supported and encouraged to the greatest extent possible.
7. Treatment and care reflect the principles of trauma-informed care at all times.
8. Treatment and care are provided in ways that support and respect individual needs and preferences with regards to language, culture, age, developmental stage, disability (including physical, intellectual and developmental disability and neurodiversity), gender, sexuality and capacity.
9. Staff have access to the necessary education, training and support to enable them to fulfill their roles in promoting the sexual and reproductive health and sexual safety of consumers, and responding to sexual safety incidents.
10. All sexual safety incidents are appropriately responded to, reported, documented and reviewed.
11. Service responses to sexual safety incidents adhere to the principles of a restorative just culture.

4 Governance, leadership and culture to support sexual health and safety

Leadership plays a pivotal role in creating a culture in which the sexual health and safety of consumers is protected and prioritised. Clinical governance, leadership and culture to support sexual health and sexual safety can be demonstrated through the following [2]:

- Leaders at all levels set clear expectations and demonstrate a commitment to protecting sexual health and safety.
- Roles and responsibilities are clearly defined.
- Clear processes are in place to support accountability and oversight.
- Staff are empowered to take initiative, voice concerns and contribute to continuous improvement.

- Staff training and development opportunities are provided to enhance skills and knowledge.
- Cultural competence and culturally safe care are prioritised.
- Services implement best practice in supporting sexual health and in preventing, identifying and responding to sexual safety incidents.
- Services actively support a restorative just culture to enable high quality care.
- Interdisciplinary collaboration and teamwork inclusive of the Lived Experience (Peer) workforce are standard, and diverse perspectives are respected and valued.
- Services engage in continuous quality improvement activities through clinical review processes, audits, the involvement of consumers and carers in service evaluation, and the implementation and monitoring of service improvements.

5 Sexual and reproductive health

5.1 What is sexual and reproductive health?

Sexual and reproductive health is a state of physical, emotional, mental and social wellbeing in relation to sexuality and reproduction; it is not merely the absence of disease, dysfunction or infirmity [3]. A multi-system, holistic approach is essential, as sexual and reproductive health involves mental health and social wellbeing in addition to the genitourinary, endocrine and immune systems.

The Queensland Sexual Health Framework [4] recognises that good sexual and reproductive health is fundamental both to an individual's health and wellbeing, and to the social and economic enhancement of individuals, communities and countries.

5.2 Sexual and reproductive health as a routine part of care in MHAOD services

5.2.1 Why consumers are a priority group

The Queensland Sexual Health Framework identifies MHAOD services as priority settings for the inclusion of sexual and reproductive health care in routine practice. This is important because:

- Consumers face heightened risks to sexual and reproductive health as a result of mental illness, comorbidities, substance use, prescribed medication, and diverse individual factors.
- Consumers can experience a deterioration in mental health secondary to changes in their sexual and reproductive health, for example pre-menstrual dysphoric disorder, peri-partum affective and psychotic disorders, and menopause.
- Consumers commonly encounter significant barriers to accessing sexual and reproductive health education and care due to trauma, stigma, and reduced health literacy and social functioning.

- Consumers who have experienced childhood sexual abuse and other trauma are more likely to experience poor mental health and, independently, poor sexual and reproductive health. This can result in complex co-morbidities such as Hinman's syndrome, pre-pubertal human papillomavirus (HPV) or other sexually transmitted infections.
- Consumers with a history of sexual trauma are at greater risk of experiencing sexual safety incidents and associated re-traumatisation.
- Psychotropic medications can have detrimental effects on sexual and reproductive health via direct mechanisms or side effects (e.g. anorgasmia) as well as via indirect mechanisms leading to sexual dysfunction (e.g. hyperprolactinaemia or metabolic syndrome) [5].
- Medication side effects and/or a deterioration in sexual and reproductive health are known causes of medication non-adherence and disengagement with mental health treatment [6]. Medication non-adherence is associated with an increased risk of relapse, readmission and mortality [7], [8].

5.2.2 Sexual and reproductive health care in MHAOD services

MHAOD services should routinely include sexual and reproductive health as part of assessment and care provision. Ensure sexual and reproductive health care is inclusive and tailored to the individual needs of consumers. Refer to section 20, Prompt sheet 2 for information about specific considerations for diverse consumer populations.

Assessment and risk management

This should include:

- Sexual and reproductive health assessment as a routine part of intake/admission processes.
- Consideration of identified sexual health risks as a routine part of risk management. Risk mitigation strategies should be identified and implemented in collaboration with the consumer (and where appropriate, families and carers).

Providing sexual and reproductive health information

MHAOD services should routinely provide sexual and reproductive health information for consumers. This should include the following:

- Provide generalised sexual and reproductive health information (see links below) to all consumers accessing services, for example by placing posters and other written materials in waiting rooms, on walls and in bathrooms in MHAOD services, with due regard for age-appropriate and Easy Read or translated materials where appropriate to the consumer population of the service.
- Provide individualised sexual and reproductive health information to consumers where appropriate and indicated, taking into account the service setting and consumers' individual circumstances. For example, this might include information about sexual orientation, sexual identity, safe sex practices, contraception, consent, relationships, sexual safety, how to access sexual and reproductive health care, and (where relevant) how prescribed medications may affect sexual and reproductive health.

For sexual health fact sheets, brochures, quick-reference tools and other resources for consumers and staff, refer to:

- Sexual health promotion resources | Queensland Health or go to www.health.qld.gov.au and type 'sexual health promotion resources' into the search bar
- True relationships (www.true.org.au)
- Sexual Health Quarters (www.shq.org.au).

Referring to specialist services

Sexual and reproductive health services is an umbrella term encompassing a broad range of services for men and women that aim to provide care that can include education about safe and healthy relationships, prevention and treatment of sexually transmitted infections, fertility and infertility care, access to contraception and abortion care, pregnancy and perinatal care and protection from sexual and gender-based violence.

MHAOD services should refer to (and support consumers to access) services for sexual and reproductive health care such as general practitioners, sexual health services, community-controlled health services and specialist outpatient services such as gynaecology, urology and endocrinology.

The Queensland Health internet website provides a list of Queensland sexual health and HIV services. These include:

- public and non-government sexual health and HIV services
- Aboriginal and Torres Strait Islander community-controlled health services
- STI and blood-borne virus testing sites
- contact tracing services.

Refer to Sexual health | Queensland Health or go to www.health.qld.gov.au and type 'sexual health' into the search bar.

Refer also to Domestic and Family Violence (DFV) information and resources for health workers or type 'DFV' into the Queensland Health intranet (QHEPS) search bar. This page includes a 'Contacts and referrals' link for DFV supports and services, both within and external to Queensland Health.

Staff education and training in sexual health

Queensland Health provides access to free sexual health education sessions and workforce development programs for health workers through the Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine. Refer to Sexual health training for health providers | Queensland Health or type 'Sexual health training for health providers' into the Queensland Health intranet (QHEPS) search bar.

In addition, a range of sexual health education resources for MHAOD staff are available at Insight (https://insight.qld.edu.au/) – specialist providers of alcohol and other drug training, education and workforce development.

5.3 Understanding sexual consent

Sexual consent is a key concept in sexual health and sexual safety. As defined by the Queensland Criminal Code s348, (sexual) consent means all parties involved in a sexual act must:

- ask for consent
- give consent clearly through speech or body language
- fully understand what they are agreeing to
- have the capacity to consent, and
- have not been coerced, threatened, pressured or tricked into it.

Additionally, the Queensland Criminal Code states that:

- Consent is an ongoing process and can be withdrawn at any time.
- A person cannot give consent to a sexual act if they are asleep or unconscious.
- A person cannot give consent to a sexual act if they are under 16 years of age.
- A person might not have capacity to give consent due to an intellectual, psychiatric, cognitive or neurological condition, or if intoxicated by alcohol or other drugs.

For further information refer to the Queensland Government consent laws website, available directly at Consent laws in Queensland | Community support | Queensland Government or go to www.qld.gov.au and type 'Consent laws' into the search pane.

6 Sexual safety

Breaches of sexual safety are rare in general health service settings [9]. However, despite preventive efforts, the occurrence of sexual safety incidents in mental health services is consistently identified as an issue in Australia and overseas, especially in inpatient settings [9] [10].

6.1 What is sexual safety?

Sexual safety means being and feeling safe from any unwanted behaviour of a sexual nature, including sexual harassment and sexual assault, sexual language and observing sexualised behaviour [11]. All consumers, family, carers, staff and visitors have the right to be and feel safe in MHAOD services.

6.2 What is a sexual safety incident?

A sexual safety incident in MHAOD services is any witnessed, suspected, disclosed or alleged occurrence of:

- sexual assault
- sexual harassment
- sexually disinhibited behaviour
- sexual activity in MHAOD service settings.

A consumer's perception of sexual safety can be impacted by behaviours and events that do not necessarily constitute a sexual safety incident as defined here. This underscores the importance of providing health care and health care environments that are trauma-informed and considerate of individual needs and preferences.

6.2.1 Sexual assault

Sexual assault is any unwanted sexual act that is forced on a person without their consent, including where intimidation, physical force, or coercion are involved. Sexual assault includes rape and attempted rape, unwanted sexual touching or groping, or being forced to perform or watch an indecent act. Sexual assault is a crime under Queensland's Criminal Code.

Sexual assault can have devastating impacts on the health, wellbeing and life outcomes of victim-survivors, and the trauma can also impact families and carers. Access to timely, trauma-informed and culturally responsive services in the immediate aftermath of an assault and in the longer term can assist in recovery [12].

6.2.2 Sexual harassment

Sexual harassment is any unwelcome conduct of a sexual nature that is carried out to offend, humiliate or intimidate another person, or where it is reasonable to expect the person targeted might feel that way. It includes uninvited physical intimacy such as touching in a sexual way, uninvited sexual propositions and remarks with sexual connotations [12]. It also includes sexual harassment via a phone, smart device or the internet, such as unwanted sexting and image-based abuse (sending intimate images of someone without their consent or threatening to do so) [13], [14].

Sexual harassment is recognised as unlawful under Queensland's *Anti-discrimination Act 1991*. Sexual harassment does not have to be repeated or ongoing to be against the law. Some forms of sexual harassment are also classified as criminal offences under Queensland's Criminal Code, such as indecent exposure and image-based abuse.

6.2.3 Sexually disinhibited behaviour

Sexual disinhibition involves an impaired ability to restrain sexual impulses, and presents as poorly controlled behaviour of a sexual nature where sexual thoughts, impulses or needs are expressed in a direct or disinhibited way, such as in inappropriate situations, at the wrong time or with the wrong person [9]. Sexual disinhibition is often a symptom of mental illness but can also be associated with alcohol and other drug intoxication, an acquired brain injury, intellectual or developmental disability and dementia or other cognitive impairment.

Sexually disinhibited behaviour displayed by consumers is a risk to sexual safety because:

- consumers are more vulnerable to sexual exploitation or assault when sexually disinhibited
- consumers who are sexually disinhibited may pose a risk to the sexual safety of others
- other people may find witnessing sexually disinhibited behaviour to be traumatic, especially those with a history of sexual assault and trauma.

Identifying and responding to sexually disinhibited behaviour is a vital part of maintaining sexual safety in MHAOD service settings. When a consumer is displaying sexually disinhibited behaviours, take immediate measures to protect them and others to ensure sexual safety. Refer to section 11.10 Responding to sexually disinhibited behaviour.

6.2.4 Sexual activity in MHAOD service settings

Sexual activity refers to any activity of a sexual nature (including touching, intercourse, oral sex) that occurs between people [9]. Sexuality is fundamental to the human condition, and consumers have the same desire for intimate relationships and sexual expression as everyone else [15]. Australian human rights include the right to sexual activity by consenting adults in private [16].

However, sexual activity is not considered appropriate in any MHAOD service setting, and falls outside the scope of acceptable behaviour within a health care environment. Sexual activity in MHAOD settings carries a high risk of psychological or physical harm for consumers. MHAOD services have a responsibility to provide a safe treatment environment for all consumers. It is not always possible to prevent harm to consumers who participate in or witness sexual activity in a health care environment, particularly when the level of acuity is high or there is rapid turnover of consumers [15], and when many consumers have a history of trauma.

To protect consumer safety and reduce the likelihood of sexual safety incidents, sexual activity is not permitted in any MHAOD service setting. Limited exceptions are discussed below.

Sexual activity, whether or not it may appear consensual, can cause harm to participants and witnesses, and carries particular risks in MHAOD service settings. For example, consumers may:

- have impaired capacity to consent to sexual activity (this can vary over time)
- have an increased risk of sexual assault due to sedative side effects of medication, alcohol or other drug intoxication, or as a direct consequence of a mental illness
- be vulnerable to coercion and exploitation
- experience sexual disinhibition or have impaired judgement, which can lead a consumer to make decisions that they would not make when well
- find witnessing sexual behaviour distressing or traumatising
- be at risk of re-traumatisation due to a history of sexual assault or other trauma
- feel unsafe if they are aware of sexual activity occurring in the service setting.

Involvement in sexual activity in MHAOD settings can have consequences for consumers such as psychological, physical or reputational harm, pregnancy and sexually transmitted infections.

Limited exceptions to sexual activity not permitted in MHAOD services

Private masturbation

Masturbation is a normal and healthy part of sexual expression. Masturbation in private settings where it cannot be witnessed by other consumers, visitors or staff is not considered a sexual safety incident. Staff should:

- where appropriate, talk with consumers about behaviours that are private (for example, showering or getting changed in privacy) and extend this to sexual behaviours that require privacy
- be conscious of giving consumers privacy, for example by knocking on bedroom doors prior to opening.

A consumer should never be shamed for engaging in private masturbation if a staff member has intruded on this activity.

Consideration should be given to consumers in extended care settings who may be subject to high levels of visual observation while in an otherwise private space such as a bedroom.

Community-based residential settings

In MHAOD community-based residential services, consumers may have a greater level of autonomy. When working with consumers to support their sexual health and sexual safety, treating teams in community-based residential settings may choose, on a case-by-case basis, to exercise some flexibility in expectations regarding sexual behaviour within the residential setting. Such decisions should be guided by a comprehensive risk assessment process. Care must be taken to ensure that:

- the consumer understands the specific expectations that apply to them regarding sexual behaviour in the MHAOD service setting
- care planning and provision of care involve all points listed in section 6.3 Sexual safety when a consumer is on leave.

6.3 Sexual safety when a consumer is on leave

Consumers residing in MHAOD services (whether in acute or extended care settings) have a right to engage in sexual activity when on leave. Where a consumer expresses a desire or intent to engage in sexual activity while on leave, care planning and provision of care should:

- respect the consumer's rights, dignity and autonomy
- support the consumer to make informed decisions about sexual practices
- routinely involve a discussion about sexual and reproductive health, the use of contraception and (where appropriate) pre-exposure prophylaxis, and the potential impact of any prescribed medications on sexual functioning
- support and encourage access to sexual and reproductive health care, including sexual health screening
- involve collaborative risk assessment and safety planning to identify and address risks to the consumer and others. This should include information and encouragement for the consumer about seeking help if they experience sexual harassment or assault, or otherwise feel sexually unsafe.

7 Communicating for sexual safety

Safe and consumer-centred care requires that information is shared as often as possible between clinicians, consumers and others involved in helping a person's recovery, while having due regard for privacy and confidentiality [17].

When and how information about a consumer can be shared with others depends on the purpose for sharing the information, who it is being shared with, and the person's capacity to provide informed consent to their information being shared [17].

Legislation and prescribed agreements are in place to support sharing of relevant information in certain circumstances. Refer to the Queensland Health internet webpage on information sharing in mental health alcohol and other drugs services (access directly via Information sharing | Queensland Health or go to www.health.qld.gov.au and type 'Information sharing in mental health' into the search pane).

7.1 Empowering consumers

Consumers have a critical role to play in contributing to the sexual safety of the service environment, their own sexual safety and that of others. Regardless of care setting or illness acuity, promoting a culture of sexual safety includes supporting consumers to participate in decision making about all areas of their lives, including sexual safety [11].

- Discuss with consumers (and where possible and appropriate, families and carers) their preferences in relation to treatment and support needs, including those relating to sexual health (refer also to section 5.2: Sexual and reproductive health as a routine part of care in MHAOD services) and sexual safety.
- Take into consideration individual needs and preferences with regards to language, culture, age, developmental stage, disability (including physical, intellectual and developmental disability and neurodiversity), gender, sexuality and capacity.
- For consumers whose capacity to make informed decisions fluctuates, consider the use of tools to support consumer choices such as the use of Advance Health Directives for Mental Health and/or the appointment of a substitute decision maker.

7.2 Orientation to bed-based services

Upon admission to a bed-based service, or as soon thereafter as possible, information should be provided to consumers, family members and significant others in relation to sexual safety. Information should be tailored to the service setting and should be provided in ways that are considerate of the diversity and communication needs of individuals accessing the service.

Local policies and/or procedures for sexual safety should define acceptable standards for behaviour in MHAOD service settings. As a routine part of induction into any health care setting, expected standards of behaviour should be discussed with consumers verbally, and displayed prominently on walls and noticeboards.

Information could include:

- Everyone's rights to sexual safety.
- Expected standards of behaviour to protect the rights, privacy and safety of consumers, staff and other people visiting or accessing the service. These might include, for example, being respectful of others; not entering the rooms or bathrooms of other consumers; not touching or speaking in a sexual manner to other consumers, staff or visitors; and not taking or sending an image of another person without their consent.
- How to raise a concern, make a complaint or report any sexual safety incident.
- Reassurance that where consumers report feeling unsafe or disclose an incident, this information is taken seriously and the response from staff will be timely and compassionate.
- Specific information such as:
    - any form of sexual harassment or assault is not acceptable
    - sexual activity is not permitted while in or on the grounds of the facility, with an explanation that this is to protect the consumer's safety and that of others
    - private masturbation is permitted (refer to section 6.2.4 Sexual activity in MHAOD service settings; specifically, the subsection 'Limited exceptions').

- Advice about appropriate and safe use of personal electronic devices (laptops, tablets and smart devices) and the internet, including social media, to support a consumer's personal privacy and safety, and that of others. Refer also to section 9.4 Addressing eSafety risks.
- The availability of:
    - sexual health and sexual assault response services and other relevant services for information, support and advocacy
    - interpreter services and transcultural services for consumers from culturally and linguistically diverse backgrounds
    - Aboriginal and Torres Strait Islander Health and/or Mental Health Workers.
- Avenues for making complaints, and options for consumers and their families to access support and assistance in relation to making a complaint, including the right to independent advocacy support.

7.3 Communicating with families and carers

For most consumers, sharing of information with families and carers is a crucial part of the recovery process. Sharing of information with families and carers should take into account the consumer's preferences, privacy and confidentiality requirements, and provisions for information sharing in legislation and prescribed agreements.

Regular information sharing that includes families and carers can assist them to recognise and respond to risks and to navigate the challenges of being a carer. Families and carers may also be able to provide staff with information relevant to sexual safety such as a consumer's trauma history, specific triggers or risks.

Communicate with families and carers about any key sexual safety risks in relation to the consumer, how the service supports sexual safety and how to communicate with the service about any concerns in relation to sexual safety.

Consideration should be given to:

- The consumer's preferences and rights in relation to sharing of information.
- Where gender diversity or aspects of culture may require sensitive or limited disclosure of information.
- Where sharing information may increase the risk of a consumer being subjected to domestic or family violence (refer to the Domestic and family violence information sharing guidelines).
- The role of each family member or carer and what information is reasonable to share to support them in this role.
- The communication needs or preferences of families and carers.

7.4 Communicating with other providers

Assessment, care planning, safety planning, providing care, transferring care and responding to sexual safety incidents can all require collaboration and communication with other MHAOD services, medical services, sexual assault response teams, police, Child Safety and other partnering services.

Staff are responsible for protecting personal, sensitive and confidential information. Consumer consent should always be sought prior to sharing information. Where consumers are unable to provide consent, or it is not possible to seek consent, provisions in the legislation and in relevant information sharing agreements allow for sharing or releasing information in circumstances where it is necessary for consumer care or required under law.

For guidance about information sharing supported by relevant legislation and agreements, refer to:

- Queensland Health webpage on information sharing in mental health alcohol and other drugs services (access directly via Information sharing | Queensland Health or go to www.health.qld.gov.au and type 'Information sharing in mental health' into the search pane).
- Queensland Government Interagency Guidelines for responding to children, young people and adults who have experienced sexual assault or child sexual abuse.

8 Assessing sexual safety risks

Assessing sexual safety risks is an essential part of broader risk assessment processes. Sexual safety risk assessment is a dynamic process undertaken both regularly and at any time that a change to sexual safety risk is identified.

Assessment of sexual safety risk should consider the following [15]:

- personal characteristics such as age and developmental stage, gender, LGBTIQ+ identity, cultural background, disability status and any language and communication needs (refer to section 20, Prompt sheet 2 for considerations for a range of diverse consumer groups)
- symptoms or conditions that may increase risk such as hypomania, mania, sexual disinhibition, disorientation or confusion, impulsivity, cognitive impairment, and the behavioural and psychological symptoms of dementia
- substance use or dependence
- actual or potential sedation, disinhibition or confusion caused by medication
- a known or suspected history of trauma, including sexual abuse, assault and/or domestic and family violence
- a history of perpetrating interpersonal violence, sexual offending or assaultive behaviour
- a history of sexually inappropriate behaviour
- subtle means of coercion, grooming or manipulation
- age-inappropriate sexual behaviour (for example, overtly sexual behaviour in children).

Refer to the Assessing and responding to violence (ARV) framework (previously known as the Violence Risk Assessment and Management Framework) and also to the Domestic and Family Violence (DFV) information and resources for health workers on the Queensland Health intranet (QHEPS). These and other resources related to risk can be found at Recognising and responding to risk in mental health, alcohol and other drug services | Mental Health, Alcohol and Other Drugs Branch (or go to the QHEPS homepage and type 'Recognising and responding to risk' into the search pane).

Families and carers and agencies such as Child Safety, corrective services or police may hold information relevant to identifying and managing risk. For guidance about information sharing supported by relevant legislation and agreements, refer to the Queensland Health webpage on information sharing in mental health alcohol and other drugs services (access directly via Information sharing | Queensland Health or go to www.health.qld.gov.au and type 'Information sharing in mental health' into the search pane).

A risk assessment should also take into account environmental factors such as:

- the physical environment (refer to section 9.2 Service environment and design)
- the acuity of, and identified risks posed by, other consumers within the health care environment
- the safety needs of other consumers within the health care environment
- the level of staff supervision/observation available or provided.

9 Mitigating sexual safety risks

Risk mitigation strategies for consumers identified as vulnerable should take into account their history, clinical presentation, risks identified in the comprehensive risk assessment and the setting in which the consumer is receiving treatment. Sexual safety risks and mitigation strategies should be discussed and routinely reviewed during clinical handover and at multidisciplinary team meetings, and documented in each consumer's clinical record, including alerts where appropriate.

9.1 Safety planning

Safety planning for sexual safety is a vital part of broader safety planning. It is a dynamic process that must be undertaken regularly and reviewed at any time that a change to sexual safety risk is identified.

Safety planning should be undertaken in collaboration with each consumer in ways that promote supported decision making, including the use of accessible language to assist consumer understanding. Safety planning should also involve families and carers where appropriate. Collaboration and information sharing with other agencies such as child safety, corrective services or police may be beneficial to the development of an effective plan.

Safety planning for sexual safety includes the following:

- In collaboration with the consumer, and where appropriate family/carers, identify:
    - what will help the consumer to be and feel sexually safe
    - how the consumer can contribute to a sexually safe environment
    - who to speak to about sexual safety concerns or incidents.
- For consumers in the community, and for inpatient consumers when leave or discharge is planned, the following should be undertaken:
    - Discussions about sexual safety in the community, including conversations about safe relationships, consent and safe sex (tailored to the consumer's age, developmental stage and individual circumstances) Refer also to section 6.3 Sexual activity when a consumer is on leave.
    - Where indicated, referral to appropriate services to support sexual health and sexual safety, including identifying whether the consumer has a general practitioner.

- When discharging consumers at night from emergency departments or inpatient units, wherever possible ensure the person has a home or other safe place to go to, and safe transport arranged (e.g. with a family member, or provide the consumer with a taxi voucher if possible).
- In bed-based services, decisions on bed allocation should include consideration of sexual safety [15], and should involve:
    - a risk assessment, including (where appropriate) collateral information from families and carers
    - a discussion with consumers about their safety and their preferences
    - an assessment of the areas best able to support their physical and psychological safety, with due regard for other consumers' safety. For example, for consumers that are gender-diverse or have other vulnerabilities, consider flexible use of beds, choice of bathrooms, and proximity to the staff work area. The wishes of the consumer should be respected and accommodated where possible.
- In bed-based services, ensure the consumer is aware of behavioural expectations.
- Where a lawful search of a person or their belongings is undertaken, the needs of the person (including sexual safety needs) should be recognised and respected to the greatest extent possible. Refer to the Chief Psychiatrist Policy: Searches and security.

9.2 Service environment and design

Consideration of the service environment is an important element of promoting sexual safety. When planning, developing, reviewing or upgrading services, consider the following factors in promoting sexual safety. It is acknowledged that some factors may be challenging to implement in existing facilities.

- staffing numbers, staffing mix and placement of staff throughout the unit
- the placement of staff work areas to enable effective and appropriate observation and support of consumers when required
- flexible use of space to support safety and enable a response to diverse consumers who may be vulnerable for a variety of reasons, for example, gender, age, trauma history, ethnicity, culture, physical health, disability, or neurodiversity [18], [19]
- clear, accessible signage to support consumers to navigate independently (for example use icons, Easy Read format, plain language and high contrast)
- gender-specific bedrooms with proximity to nurse stations
- consumer-controlled, lockable bedrooms and ensuites
- male, female and gender-neutral bathrooms in shared areas
- access to safe and private space for all consumers
- access to gender-specific or otherwise safe space for all consumers, with use of swipe controls where possible and appropriate
- recreational areas that vary in size and design to enable choice and autonomy, and to support both shared and solitary activity
- visiting areas that facilitate privacy and safety
- fittings, such as window coverings, to improve privacy

- movement sensors in common areas
- CCTV in common areas
- adequate lighting in all areas
- access to duress alarms for consumers
- elimination of blind spots.

Safety features such as movement sensors and CCTV are designed to support safe practice and must not replace staff presence throughout the ward or regular observations.

9.3 Considerations for consumers under 18 in adult inpatient units

Wherever possible, inpatient treatment for young people under the age of 18 should be provided separately from adults (refer to the Chief Psychiatrist Policy: Treatment and Care of Minors).

Where it is deemed necessary to admit a young person to an adult facility:

- environmental adjustments must be considered to enable accommodation in as safe a location as possible
- particular care must be taken to plan, implement and document adequate clinical observation and supervision arrangements to ensure the young person's sexual safety
- a transfer to an age-appropriate service should be arranged as soon as possible
- refer to Queensland Health guidelines regarding the admission of adolescents to adult mental health inpatient units for more information.

9.4 Addressing eSafety risks

Consumers can experience or perpetrate sexually abusive behaviour via technology such as laptops, tablets, smart devices and social media. It is important to cover the safe use of devices and social media as part of orientation to the service, and consider it as part of risk assessment. Information should be provided about expected standards of behaviour and the rights, privacy and safety of consumers, staff and other people visiting or accessing the service. Resources that may be useful for staff, consumers and family/carers include the following:

- *Chief Psychiatrist Guidelines for operationalising* Mental Health Act 2016 *order or authority conditions requiring monitoring of electronic devices*. This is relevant where conditions requiring the monitoring of an involuntary consumer's electronic device and/or internet access have been imposed through a forensic order, treatment support order or treatment authority.
- The eSafety Commissioner is Australia's independent regulator for online safety. Their website www.esafety.gov.au provides tools and resources to inform and assist adults and children to maintain online safety. The eSafety Commissioner also offers support for people experiencing online harm including investigations and removing dangerous content.
- ThinkUKnow is an evidence-based cyber safety program that provides accessible cyber safety education, developed and delivered in collaboration with state and territory police services. Their website www.thinkuknow.org.au provides information about technology and youth, privacy, relationships and reputation management.

10 Identifying sexual safety incidents

Staff may become aware of a sexual safety incident involving a consumer through:

- a disclosure or report from the affected consumer
- witnessing an incident
- an incident being reported by a third party
- observing significant changes in the behaviour or presentation of the consumer (for example, distress or anger, panic symptoms, withdrawal, changes in eating and sleeping patterns, suicidality, self-harm)
- the consumer reporting physical symptoms, or these symptoms being observed and reported by another person
- reviewing CCTV footage.

10.1 Being aware of barriers to disclosure

Most incidents of sexual assault or harassment go unreported, even in the general population [20]. Consumers in MHAOD services face additional barriers to disclosure of sexual safety incidents.

Staff should be alert to barriers to disclosure and consider strategies to support disclosure. Examples of barriers [15] include:

- fear of not being believed, or of being blamed or judged
- lack of confidence that the incident will be taken seriously or acted upon appropriately
- feelings of shame, shock or distress
- fear of the alleged perpetrator
- fear that the disclosure will be interpreted as a symptom of illness, and/or that reporting the incident could lead to more assertive or restrictive treatment
- worries about privacy and confidentiality
- difficulties communicating
- cultural requirements or taboos relating to sex and sexuality
- concerns about dealing with police and courts
- being uncertain or unaware of what is abusive.

11 Responding to sexual safety incidents

11.1 MHAOD service staff responsibilities

In responding to a sexual safety incident, whether it occurred recently or in the past, staff have the following responsibilities. This is the case even where the clinical assessment is that the incident is unlikely to have occurred.

- Treat any disclosure or allegation as serious.
- Attend to the immediate safety and the medical and mental health needs of all persons affected, as described in this guideline.
- Offer options for forensic medical examination, support and advocacy services and reporting to police.
- Report the incident in alignment with local procedures, including immediate notification of senior staff and (where appropriate) reporting to police and/or Child Safety and/or the Chief Psychiatrist. Refer to section 17 Reporting of sexual safety incidents, and section 11.11 Responding to allegations and reports that are inconsistent with evidence.
- Work collaboratively with police and other services involved.
- Ensure clear and accurate documentation, and follow clinical incident review processes.

MHAOD service staff are not responsible for:

- substantiating allegations of sexual safety incidents
- judging or assessing whether sexual assault or harassment has occurred
- determining whether a criminal offence has occurred.

These are the responsibility of the police and the courts [24].

A one-page prompt sheet for staff who are responding to sexual safety incidents is at section 20, Prompt Sheet 1.

11.2 Establishing safety after an incident

The initial priority is to ensure the immediate safety of the affected consumer, and any others impacted, taking into consideration both physical and psychological safety.

- Immediately notify the nurse unit manager/team manager or after-hours manager/on-call psychiatrist (refer to additional responsibilities under section 17 Reporting of sexual safety incidents).
- Ensure there is a quiet, safe space for the affected consumer away from the scene of the incident where possible, and away from the alleged perpetrator. Allocate a staff member to stay with them, taking into consideration consumer preferences with regards to gender wherever possible.
- Attend to any immediate medical needs. Arrange for a medical examination (with consumer consent). Where sexual assault has been alleged, the police should be contacted (see section 17.4 Reporting to police) and a forensic examination should be offered to the consumer.
- It may be necessary to preserve the scene of the incident for examination by police (see section 17.4.3 Preserving evidence).
- Move the person accused of a sexual safety breach to a safe space. Complete a risk assessment to determine any risk to self or others, and put safety measures in place accordingly.

- Note that moving any consumer to a different service environment, especially a more restrictive environment, should be in response to clinical need and wherever possible in alignment with the person's preferences. In particular, consider carefully before moving the alleged victim-survivor to a more restrictive setting, as this may be perceived as punitive and could cause more distress.

11.3 Supporting a consumer following a sexual safety incident

Regardless of the nature of the incident, all disclosures regarding sexual safety incidents must be taken seriously and responded to in an inclusive, sensitive, supportive and trauma-informed manner.

- If the consumer requires communication supports, arrange for this assistance to be in place immediately and throughout the process, including during medical examinations, police interviews and follow-up. This may include interpreters, speech-to-text, pictorial aids, and Easy Read materials.
- Ask if the consumer would like a support person of their choice to offer immediate support alongside staff. Assist in arranging for this person to be contacted. This may be a partner or family member, friend, community support worker, counsellor, Lived Experience (Peer) worker or advocate.
- Allow the consumer to talk about the experience in their own words, at their own pace.
- Give consumers the option to share as much or as little information as they are comfortable with, in whatever way they prefer (for example, being given the option to draw or write things down).
- Listen to the consumer's story and let them know they are believed.
- Avoid asking the consumer to retell their story multiple times to different staff. This can cause further trauma.
- Offer sensory regulation options to reduce distress. Examples include a quiet, low-stimulation space (dim lighting, reduced glare), access to fidget tools, noise-cancelling options. Consumer preference must guide these supports, as some sensory modalities may exacerbate distress. Where indicated, consider Occupational Therapist input for sensory regulation.
- Guide the consumer through each stage of the process by providing information, discussing one step at a time, and allowing the consumer time to understand and consider the information provided. Use accessible information formats such as visual timelines and plain language summaries.
- This level of support should always be offered when a consumer discloses a sexual safety incident, even when the clinical assessment indicates that the event is unlikely to have occurred. A dismissive response can contribute to trauma and hinder effective engagement.
- For additional information about supporting someone who has disclosed sexual assault or harassment, refer to the Queensland Sexual Assault Network website www.qsan.org.au or the National Domestic and Family and Sexual Violence Counselling Service (1800RESPECT) website at www.1800respect.org.au.

11.4 Reviewing risk assessment and safety planning

Following a sexual safety incident, risk assessments, safety plans and alerts should be reviewed and updated for all involved consumers, including witnesses, with discussion as part of a multidisciplinary team review. Document relevant actions and decisions in each consumer's clinical record. For more information refer to section 8 Assessing sexual safety risks and section 9.1 Safety planning.

11.5 Referring to specialist services

11.5.1 Sexual assault counselling and support services

Where a sexual assault has been alleged, a sexual assault support service should be contacted by the MHAOD service with the consent of the consumer. Some consumers may prefer to contact the service themselves.

In addition to direct support for the consumer, sexual assault support services can provide advice to MHAOD service staff about assistance available to the consumer, how to support the consumer and others impacted, the rights of the consumer, police reporting and interview processes, forensic medical examinations and so forth.

MHAOD service local procedures should have a list of local sexual assault services as well as national or statewide websites and telephone-based services such as the Statewide Sexual Assault Helpline (1800 010 120), 1800 RESPECT (1800 737 732) and DV Connect (1800 811 811 or www.dvconnect.org).

The Queensland Health internet website provides a list of sexual assault support services in Queensland. Refer to www.health.qld.gov.au/sexualassault/html/contact or go to www.health.qld.gov.au and type 'sexual assault support' into the search bar.

The Queensland Sexual Assault Network (peak body in Queensland) also provides a list of sexual assault support services and other support services in Queensland, and resources for victim/survivors and staff. See their website at www.qsan.org.au.

11.5.2 Legal and other advocacy services

All consumers involved in a sexual safety incident should be given information about options for legal and non-legal advocacy. A range of non-government organisations for people impacted by sexual assault offer flexible, holistic support including advocacy, and sexual assault and crisis counselling.

For a list of services go to the Queensland Government internet site: Sexual abuse and assault: getting help | Community support | Queensland Government (https://www.qld.gov.au/community/getting-support-health-social-issue/support-victims-abuse/sexual-abuse-assault/sexual-abuse-assault-getting-help).

11.6 Responding to the person accused of a sexual safety breach

Where a sexual safety incident has occurred, all parties involved, including those accused or suspected, must be supported and treated with the assumption of belief [21].

11.6.1 Where the accused/suspected person is a consumer

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

- Ensure the consumer's treating consultant or the after-hours on-call consultant is notified.
- Continue to provide appropriate treatment and care.
- Offer sensory regulation options and private spaces to reduce distress, as needed. Examples include a quiet, low-stimulation space (dim lighting, reduced glare), access to fidget tools, noise-cancelling options. Consumer preference must guide these supports, as some sensory modalities may exacerbate distress. Where indicated, consider Occupational Therapist input for sensory regulation.
- Provide the person with information about their rights (including legal rights) and what happens next, including police involvement where applicable. Confirm comprehension of rights and next steps using plain language and visual aids as needed.
- If the consumer requires communication supports, arrange for this assistance to be in place immediately and throughout the process, including during medical examinations, police interviews and follow-up. This may include interpreters, speech-to-text, pictorial aids, and Easy Read materials.
- Ask if the consumer would like a support person of their choice to provide immediate support alongside staff. Assist in arranging for this person to be contacted. This may be a partner or family member, friend, community support worker, counsellor, Lived Experience (Peer) worker or advocate.
- Allow the consumer to give their account of what happened, in their own words.
- Undertake an assessment of risk to self and others and develop a safety plan. Manage risk accordingly, for example by increasing observations, moving the consumer to a secure or high-visibility area, or transferring the consumer to another ward or facility away from the alleged victim-survivor.
- Ensure a mental state examination is undertaken and assessment of capacity is arranged (refer to section 12 Assessing decision-making capacity).
- Arrange a medical examination if required (refer to section 13 Medical examinations and forensic examinations).

11.6.2 Where the accused/suspected person is a visitor

Where a visitor to the service is an alleged perpetrator:

- Record the visitor's details.

- Report the incident in the same ways as other sexual safety incidents, including to senior staff and police.
- Ensure culturally safe and accessible communication. Where the visitor has a disability or language barrier, engage interpreters or support workers.
- Document details of the incident in the clinical record of the involved consumer.
- Where there is an existing relationship between the visitor and consumer, consider how to support the consumer to maintain safety in their relationship.

11.6.3 Where the accused/suspected person is a staff member

When allegations of a breach of sexual safety are made against a staff member, the staff member should be supported to a private space away from the affected consumer and provided with information and assistance regarding their support needs and legal rights. Refer to section 16 Sexual contact between staff and consumers.

11.7 Responding to disclosure of past sexual assault

Where a consumer discloses past sexual assault, it is recommended that the following actions are taken [22]:

- Support the consumer to disclose only as much information as they are comfortable with, in their own words.
- If the consumer is a minor, refer also to section 11.8 Considerations for consumers under 18.
- Discuss with the consumer whether they wish to engage in counselling. The local sexual assault support service can provide current and local information about where to access sexual assault counselling. Refer also to section 11.5 Referring to specialist services.
- Provide information about options for reporting to police and support the consumer if they wish to report to police.
- Support access to medical care and/or testing (as appropriate) if not previously completed.
- Liaise with the consumer's treating team regarding ongoing support.
- Discuss with the consumer possible triggers that may cause distress in the future and how to manage these. Where the triggers are related to health care or treatment, consider including this in the care plan, safety plan or acute management plan.
- Liaise with line manager regarding reporting requirements and, if relevant, complete a report on the clinical incident management system.
- Document the disclosure and any actions taken as clearly as possible, including the consumer's own words where possible, and any actions taken.
- If the alleged assault took place in a MHAOD service setting, and/or involved a staff member, this is to be reported to the relevant line manager for appropriate escalation as soon as possible. Document who the incident was reported to and when.

11.8 Considerations for consumers under 18

11.8.1 General considerations

Communicating with children and young people about sexual safety matters can be challenging and will require staff to utilise a variety of communication strategies and therapeutic approaches. Families, carers and other support people, in addition to MHAOD service staff, perform an important role in supporting young people to understand sexual safety messages, raise concerns if they feel sexually unsafe, and disclose when incidents of sexual assault or harassment occur.

Where a consumer of a MHAOD service who is under the age of 18 years discloses an allegation of sexual assault or sexual harassment, or sexual abuse is suspected, staff should be guided by the statutory requirements under the *Child Protection Act 1999*, the *Public Health Act 2005*, the *Mental Health Act 2016* and the Queensland Criminal Code.

When working with young people, staff should use developmentally appropriate language and communication aids, offer sensory-friendly spaces, and involve family/carers where safe and appropriate, and ensure interpreters and cultural liaison officers are available.

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

In these circumstances staff should refer to local policies and procedures, which should be consistent with existing legislation and statewide policies and guidelines. The service response should include comprehensive documentation about the incident, the consumer's expressed wishes (for example, to report to police; to advise parents) and the actions taken by the service.

11.8.2 Suspicion of child sexual abuse

Mandatory and non-mandatory reporting to Child Safety

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

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

a) a child (under 18 years of age) may be in need of protection; or

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

Mandatory reporting to police

Under section 229BC of the Queensland Criminal Code it is an offence, punishable by up to 3 years imprisonment, for an adult to fail to report to police (without a reasonable excuse) a reasonable belief of a child sexual offence. The Criminal Code defines a child as a person under 16 years of age, or a person under 18 years with an impairment of the mind.

Any adult (aged 18 or over) who gains information that causes them to believe on reasonable grounds (or ought to reasonably cause them to believe) that a child sexual offence is being or has been committed by another adult (aged 18 or over) must report this to the police, unless they have a reasonable excuse (for example having already reported the information to Child Safety). Even if the offence happened a long time ago, the person must report it to police unless they have a reasonable excuse.

MHAOD services must report the matter to police if it is alleged or suspected that a person under 18 years of age has been sexually assaulted. Refer also to Section 17.4.1 When services must report to police.

Further information

For further information refer to:

- local Queensland Health child protection staff for advice and support (see the QHEPS Child Protection and Wellbeing homepage below for contact details)
- the Queensland Health intranet (QHEPS) Child Protection and Wellbeing homepage https://qheps.health.qld.gov.au/child-protection-policy
- the Queensland Health guideline *Reporting concerns of child abuse and neglect to Child Safety and sexual offences against children to the police*.

11.9 Responding to sexual activity in MHAOD service settings

Sexual activity in any MHAOD service setting is not permitted, and is to be treated as a sexual safety incident (refer to section 6.2.4 for limited exceptions).

It is important for staff to be respectful and nonjudgemental when responding to sexual activity, to ensure the parties involved do not feel demeaned, humiliated or exposed.

- Immediately intervene to stop the behaviour, discuss with the people involved, assess risk, and update safety plans for all involved consumers.
- Report to senior staff in accordance with local procedures.
- Check with consumers to ensure understanding of behavioural expectations, and offer support where consumers are distressed.
- Medical examinations may be arranged with consumer consent (refer to section 13.1 Medical examinations and section 12 Assessing decision-making capacity).
- If there has been sexual activity that could result in pregnancy or disease transmission, discuss these possibilities with the consumers. Consultation with a sexual health physician is recommended.
    - Testing for sexually transmitted infections should be recommended.
    - Prophylactic treatment should be offered after possible HIV exposure.
    - Emergency contraception should be offered where applicable (within 3-5 days of the incident, dependent on the specific medication).
    - Testing for pregnancy should be recommended where applicable.
- Record the incident on the clinical incident management system as soon as practicable.

- Ensure discussion at a multidisciplinary team meeting and follow procedures for clinical incident review.
- Ensure involved consumers have access to support and opportunities to talk, if desired, with a staff member (including a Lived Experience (Peer) worker), or a family member or other support person.
- Consider that sexualised behaviour in children may be an indicator of child sexual abuse.

11.10 Responding to sexually disinhibited behaviour

When a consumer is displaying sexually disinhibited behaviours, take immediate measures to protect them and others to ensure sexual safety. Responses should be trauma-informed, culturally safe, and inclusive of sensory and communication needs.

- Review and update the consumer's risk assessment, safety plan and alerts. Risk management strategies should incorporate strategies that have been useful for the consumer in the past. Refer also to section 9 Mitigating sexual safety risks.
- Where appropriate, seek input from family, carers, or nominated support persons to inform the response, ensuring cultural and communication needs are respected.
- Increase staff presence and provide care to help maintain boundaries.
- Ensure the consumer is adequately clothed and/or given privacy.
- Use de-escalation methods to defuse sexually disinhibited behaviours. The Safewards 'calm down methods' (for example, sensory modulation) and/or 'talk down' interventions may be useful [15]. Safewards resources can be found at www.safewards.net. Use proactive, strengths-based strategies. Additional guidance is available through contemporary frameworks such as Positive Behaviour Support and trauma-informed care models recommended by the Australian Psychological Society and Queensland Health disability inclusion standards.
- Engage the consumer in a supportive discussion about their behaviour and sexual safety, taking mental state into account. Avoid punitive or judgmental language.
- Maintain clinical vigilance to prevent, identify and respond to behaviours that place the consumer or anyone else at risk.
- Clearly document in the consumer's clinical record the behaviours, actions taken to respond, and actions to prevent and manage any further behaviours.
- Record the incident on the clinical incident management system as soon as practicable.
- Ensure discussion at a multidisciplinary team meeting and follow procedures for clinical incident review.
- Offer support to any person who may have been adversely impacted. Exposure to sexually disinhibited behaviour can be triggering or traumatic, particularly for those with a history of trauma.

11.11 Responding to allegations and reports that are inconsistent with evidence

In rare circumstances, specific aspects of a consumer's presentation (for example, hallucinations, delusions, delirium) may lead to an allegation, or a series of allegations of sexual assault or harassment, where all available evidence indicates that the alleged event/s could not have occurred.

Where it is believed that a disclosure, report or allegation of sexual assault or harassment is likely to be false or delusional:

- Consider each separate allegation on its own merits.
- Ensure any evidence such as CCTV footage is secured (refer also to section 17.4.3 Preserving evidence).
- Assess each allegation to the extent necessary to determine if further investigation (for example, by police) is required. Balance the possibility of a false or delusional allegation against the understanding that MHAOD service consumers are highly vulnerable to sexual violence [11].
- Until appropriate reporting and investigation processes have been undertaken, any allegations involving staff should not be discounted as false or mistaken, and must be treated with due seriousness.
- Be aware that disclosures of sexual violence are often fragmented, inconsistent or confused [23] and may not be coherent or made in plausible terms, but this has no bearing on the validity [11], [9].
- Record the incident on the clinical incident management system as soon as practicable.
- **The treating team is to escalate the issue to the clinical director and executive director, MHAOD services or the director of medical services (or equivalent)** for discussion and a decision regarding the course of action to be taken, including whether to report the allegation to police. The decisions made, the rationale and any actions taken must be clearly documented in the consumer's clinical record.
- **The threshold for excluding the possibility of sexual assault must be high** [9]. The specific clinical and contextual factors that justify the conclusion of exclusion should be clearly documented, ensuring any determination is made with appropriate rigour, sensitivity, and with multidisciplinary input. There should be clear evidence that the accused person could not have had access to the consumer alleging assault [11]. A lack of evidence of assault or harassment is not sufficient, as it is common in cases of sexual violence for evidence to be lacking [23].
- Regardless of whether or not the allegation is thought to be based on fact, respond to the consumer in a sensitive and trauma-informed way, undertake a risk assessment, work with the consumer to develop or update a safety plan, and implement any identified risk mitigation measures to support sexual safety.
- The decision of the service regarding whether to report an allegation to police should be discussed with involved consumers and, where appropriate, their family members or carers. Any person, including a consumer or a family member, can make a report to police if they wish. Refer to section 17.4.1 When services must report to police.

12 Assessing decision-making capacity

Capacity assessment in MHAOD services should be ongoing (as capacity can fluctuate over time) and should be considered in relation to each separate decision required. Refer to the *Queensland Health Guide to informed decision-making in health care*, which contains detailed guidance.

- After a sexual safety incident, conduct a mental status examination including a capacity assessment for all involved parties. This is not an assessment of the person's capacity to consent to sexual activity. A capacity assessment following a sexual safety incident should be undertaken by a medical practitioner.
- Capacity assessment following a sexual safety incident should evaluate the consumer's capacity to:
    - consent to a medical examination and care
    - consent to a forensic examination (if applicable)
    - understand the police reporting process (if applicable)
    - attend a police interview (if applicable)
    - collaborate with an investigation [15].
- The decision-making capacity of young people under the age of 18 years may require consideration and consultation with the multidisciplinary treating team.
    - A person under 18 is considered capable of giving informed consent for a specific matter when they are able to fully understand what is proposed (referred to as Gillick competence).
    - For further information on Gillick competence refer to the *Queensland Health Guide to informed decision-making in health care* (Part 3, Informed decision-making and consent for children and young persons).
- Provide sufficient information and support for consumers to make informed decisions.
- A person may have capacity for some decisions but not others.
- Where a person is deemed not to have decision-making capacity, they should still be involved in and informed about decisions that affect them to the greatest extent possible.
- Where a forensic examination is warranted, but the consumer is deemed not to have capacity to provide consent for a forensic examination, staff must support the consumer to access an authorised power of attorney (general or enduring), appointed Guardian, or the Public Guardian [24]. Refer to section 13.2 Forensic medical examination.
- Ensure the capacity assessment is documented.

If review with a psychiatrist or other medical practitioner is not immediately available (for example, in a service without an on-site doctor), a mental health clinician should undertake a mental state assessment and arrangements should be made for the consumer to be reviewed by a psychiatrist or other appropriately qualified medical practitioner for a capacity assessment as soon as possible [25].

13 Medical examinations and forensic examinations

13.1 Medical examination

This is not a forensic examination. The purpose of a medical examination after disclosure of a sexual safety incident is to assess physical and psychological harm, determine the consumer's immediate treatment and support needs, and assess capacity to consent to a forensic examination and/or police interview (refer to section 12 Assessing decision-making capacity). A medical examination may assist in gathering information that other agencies (for example, police) may require.

- Medical examinations are to be performed by a medical practitioner.
- Informed consent from the consumer (or where applicable, their parent or guardian) is required for a medical examination. The process of obtaining informed consent should take into account the consumer's communication needs (refer to the *Queensland Health Guide to informed decision-making in health care*). A consumer can choose not to have an examination.
- The examination should occur as soon as possible, taking into account the consumer's preferences and needs.
- Give the consumer the option to have a support person present.
- In addition to a support person, offer a chaperone of the consumer's choice for any examination the consumer might find intimate. It is suggested this be a clinical member of staff rather than a family member or friend [25].
- Take care to respect the dignity, privacy and safety of the consumer at all times during the examination.
- Comprehensively document the findings of the medical examination.
- If there has been sexual assault or sexual activity that could result in pregnancy or disease transmission, this should be discussed with the consumer. Consultation with a sexual health physician is recommended.
    - Testing for sexually transmitted infections should be recommended.
    - Prophylactic treatment should be offered after possible HIV exposure.
    - Emergency contraception should be offered where applicable (within 3-5 days of the incident, dependent on the specific medication).
    - Testing for pregnancy should be recommended where applicable.

13.2 Forensic medical examination

13.2.1 Purpose of a forensic medical examination

A forensic medical examination involves an intimate physical examination, collection of samples and documentation of injuries to collect and preserve physical evidence from the victim-survivor and their clothing, following a report of a sexual assault.

Staff should be aware of how to access a local forensic pathway of care, including specialist forensic medical assessment. Information is available on the Queensland Health intranet (QHEPS) webpage, available directly via Caring for people disclosing sexual assault | Clinical Excellence Queensland or go to the QHEPS homepage and type 'sexual assault' into the search bar.

13.2.2 When to offer a forensic medical examination

All persons disclosing sexual assault up to 7 days after the assault should be offered a forensic medical examination, and assessed to determine the timing and nature of the examination required. The examination should occur as soon as possible with the person's informed consent, as the quality and availability of the evidence deteriorates with time [26].

13.2.3 Informed consent

A forensic medical examination must have the informed consent of the consumer (or, if the consumer is a child, parental or guardian consent). The process of obtaining informed consent should take into account the consumer's communication needs (*refer to the Queensland Health Guide to informed decision-making in health care*). A consumer can choose not to have an examination.

Where an adult consumer is deemed not to have capacity to provide consent for a forensic examination, services must assist in accessing an authorised power of attorney (general or enduring), appointed Guardian, or the Public Guardian [24].

- A forensic examination is defined as a 'personal matter' in Part 2 of Schedule 2 of the *Powers of Attorney Act*; that is, not a health care matter. Substituted decision-making by a statutory health attorney is therefore not authorised for forensic examinations.
- The process of obtaining an interim order for guardianship, where this is necessary, may not allow sufficient time for the forensic examination to be performed.

13.2.4 Forensic examination options

Where a consumer consents to a forensic examination following a sexual assault, they may choose either:

- Collect and Analyse: Samples are sent to the laboratory (with police involvement) for analysis so that any results may be used in a current police investigation.
- Collect and Store – Chosen when a consumer does not want to pursue a police investigation or requires more time to decide whether or not to pursue a police investigation. Samples are sent to the laboratory (without police involvement) and stored for up to two years. Samples can be analysed within that two-year period if the consumer decides to pursue a police investigation.

The options available to the consumer, and their respective benefits, should be explained. Helpful resources are available for this purpose on Forensic Medicine Queensland's intranet (QHEPS) webpage. These include a generic patient brochure (adaptable for your HHS) and scripts for how to explain the options verbally. Refer to Patient choices | Forensic Medicine Queensland (https://qheps.health.qld.gov.au/chief-medical-officer/forensic-medicine-queensland/response-to-sexual-assault/patient-choices).

13.2.5 Additional considerations

Additional considerations for forensic medical examinations include the following:

- Dependent on local processes, the consumer may need to be medically cleared prior to a forensic examination.
- Where a forensic examination is to occur, showering, teeth brushing and rinsing of the mouth should be avoided if possible, however if the consumer is too uncomfortable or distressed, they may need to wash. This should be respected and supported.
- If the consumer changes clothes after an alleged sexual assault, each item of clothing should be placed into a separate bag, sealed and taken to the examination with the consumer.
- Forensic examinations can be distressing. The consumer should be offered the option to have a support person attend with them. MHAOD services are to assist in arranging this where needed.

13.2.6 Who conducts a forensic examination?

For adults, a forensic medical examination is performed by a trained forensic medical officer, forensic nurse examiner, or appropriately trained doctors and nurses.

For children, all health services have a role in providing an immediate response to children and young people up to 18 years of age who have experienced sexual assault. Where the child is under 14 years of age, a paediatrician may perform a forensic medical examination after the child has received initial emergency medical treatment to assess and treat injury.

Refer to Forensic Medicine Queensland (via the Queensland Health intranet QHEPS) to access protocols for paediatric examinations: available directly via Paediatric - children and younger adolescents | Forensic Medicine Queensland or go to the Forensic Medicine Queensland homepage on QHEPS and navigate to find resources for caring for people disclosing sexual assault.

14 Handover, post-incident support and open disclosure

14.1 Escalation and handover

All sexual safety incidents are to be escalated to senior staff in alignment with best practice clinical handover and local protocols. Sexual safety risks and incidents should be discussed in clinical handover with appropriate regard for confidentiality requirements and limitations, and these discussions should be documented.

14.2 Post-incident support

Senior management should ensure post-incident support is offered to everyone impacted by a sexual safety incident including consumers, family, carers, staff and visitors. This should be offered within the first 24 hours (where possible) and certainly within 72 hours after the incident has been identified.

Follow relevant local policies and procedures for supporting impacted persons after a safety incident.

14.3 Open disclosure

Open disclosure refers to the open discussion, with a consumer and their family and carers, of adverse events that result in harm to a person receiving health care.

Open disclosure processes are a key step in clinical incident management and commence upon the identification of a patient safety incident. Open disclosure encourages a culture of trust and accountability, underpinned by honesty, transparency, empathy and support [27] and [2].

The five essential elements of open disclosure are:

- an apology
- a factual explanation of what happened
- an opportunity for the consumer to talk about their experience
- a discussion of the potential consequences
- an explanation of the steps being taken to manage the event and prevent reoccurrence.

Open disclosure includes:

- Clinician Disclosure – part of the initial response to all clinical incidents. It should occur as soon as practical after the incident has been identified.
- Formal Open Disclosure – a structured process that normally occurs after a formal review of the incident. It may not be necessary for all incidents.

Health services should have local processes for open disclosure. Open disclosure should be undertaken with trauma-informed principles in mind and should take into account the individual communication needs and preferences of the consumer and any involved family and carers.

Refer also to the *Queensland Health Open Disclosure Guide* (2020) and the Queensland Health intranet (QHEPS) page Open Disclosure | Patient Safety and Quality Improvement Service (or type Open Disclosure into the QHEPS search bar).

15 Transfer of care

Following a sexual safety incident, it is important that consumers' needs are met beyond the acute phase, especially where a transfer of care is to occur from inpatient to community-based settings, or between MHAOD and other services. Appropriate sharing of information is a necessary part of this process [17].

- Services should have systems in place to ensure that inpatient teams have access to relevant trauma history when a consumer is admitted, and that information about trauma experienced during inpatient admissions is communicated as part of clinical handover discussions, alerts and discharge summaries [11].
- The consumer's right or preference not to disclose should be weighed with the need to provide the necessary information for ongoing treatment, support and risk mitigation [15].
- Discharge summaries and plans for transfer of care should outline ongoing needs and the steps required to meet these, including identification of ongoing risks and vulnerabilities [15].

- Consumers who have experienced a sexual safety incident in an acute setting should be offered support to develop an advance safety plan that identifies care preferences for future acute admissions to enhance sexual safety and reduce the risk of re-traumatisation [11].
- Where a transition of care is being considered for a young person, from child and youth MHAOD services to adult MHAOD services, refer to the Queensland Health guideline *Transition of care for young people receiving mental health services*.
- Ensure all communication takes into account the principles of trauma-informed care, and is culturally safe and considerate of individual support needs.

16 Sexual contact between staff and consumers

At no time is it acceptable for a staff member, contractor or volunteer working in a MHAOD service to behave in a sexualised manner toward a consumer, or to pursue or engage in a sexual relationship with a consumer. This is the case regardless of the position the staff member holds, who initiated the relationship, and whether or not the relationship is considered consensual.

Sexual safety incidents where a staff member is an alleged or suspected perpetrator are to be reported to the police and the Office of the Health Ombudsman. Irrespective of police involvement, disciplinary and registration issues (where applicable) should be addressed through usual processes [15].

If a Queensland Health employee is alleged to have engaged in sexual behaviour toward, or with, a consumer, appropriate action must be taken immediately. Staff are to:

- Advise the consumer that the matter will immediately be acted upon, and provide appropriate support to the consumer.
- Immediately report the concerns or allegations to senior management in accordance with local procedures.
- Arrange for the accused staff member to be removed from the vicinity as discreetly as possible. Do not share details with others of the allegations against the staff member.
- Determine whether the consumer's family or support person is to be notified, taking into account the consumer's preferences, and legal obligations (e.g. if the consumer is under 18).
- Maintain confidentiality about the incident, outside of reporting obligations.
- Maintain accurate and detailed notes in relation to the incident and action taken.
- Record the incident on the clinical incident management system as soon as practicable.
- Senior staff are responsible for taking appropriate action including internal escalation, necessary external reporting (e.g. police, Office of the Health Ombudsman), and the involvement (as needed) of Human Resources, Ethical Standards and/or Workplace Health and Safety representatives.
- 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 [15].
- Protect the staff member's rights and ensure that support and advice is made available to them.

Mandatory reporting obligations apply under the Code of Conduct for the Queensland Public Service, the Health Practitioner Regulation National Law (Queensland) and the National Code of Conduct for Health Care Workers (Queensland).

A health care worker must notify the Office of the Health Ombudsman if they form a reasonable belief that another health care worker has engaged in sexual misconduct.

Further information on registering a health complaint is available on the Office of the Health Ombudsman website at www.oho.qld.gov.au. Professional codes of conduct for health professionals are available on the Australian Health Practitioner National Agency (AHPRA) website at www.ahpra.gov.au. The National Code of Conduct for Health Care Workers (Queensland) can be found on the Queensland Government internet site (go to www.health.qld.gov.au and type 'national code of conduct' into the search bar).

17 Reporting of sexual safety incidents

17.1 Immediate reporting

Upon becoming aware of any sexual safety incident, staff reporting obligations are as follows:

- Immediately notify the nurse unit manager/team manager or after-hours manager or on-call psychiatrist. This person is responsible for escalating the report in accordance with local processes. Local procedures should have reporting lines and roles clearly outlined.
- Contact security, who can determine whether there is CCTV footage to be identified and preserved.
- Determine whether the family or support person of each affected consumer is to be notified, taking into account consumer preferences, any domestic and family violence considerations or cultural considerations, and legal obligations (e.g. if the consumer is under 18).
- Provide information to the consumer regarding options to notify the police, and consider service obligations to report to police (refer to section 17.4. Reporting to police).
- Mandatory reporting obligations to Child Safety and/or police apply where the alleged victim is under 18 years of age. For further information refer to section 11.8.2 Suspicion of child sexual abuse. For support and advice contact the local HHS Child Protection Unit, Child Protection Liaison Officer or Child Protection Advisor.
- Mandatory reporting to the Office of the Health Ombudsman applies where sexual misconduct by staff is reasonably suspected.

A consumer may choose to retract a disclosure; however, this does not mean a sexual safety incident did not occur. Risk assessment, safety planning, multidisciplinary review, reporting, recording in the clinical incident management system and documenting in the clinical record should still occur.

17.2 Recording on the clinical incident management system

All disclosures and allegations of sexual safety incidents are to be recorded in the Queensland Health clinical incident management system as soon as practicable after the incident has occurred (after attending to the safety and immediate needs of involved parties), and in alignment with local incident management procedures [28]. This is the case even where the clinical assessment is that the incident is unlikely to have occurred, and regardless of whether a consumer chooses to formally report the incident.

17.3 Reporting to the Chief Psychiatrist

In accordance with the Chief Psychiatrist Policy: Notifications to the Chief Psychiatrist of critical incidents and non-compliance with the *Mental Health Act 2016*, the following must be reported to the Chief Psychiatrist:

- All allegations of sexual assault, and any sexual safety incident resulting in significant mental or physical harm involving an inpatient of an authorised mental health service.
- Any incident affecting the health, safety or wellbeing of a consumer or another person which could attract public attention or adversely affect the organisational reputation of the authorised mental health service.

17.4 Reporting to police

When a report is made to police by MHAOD service staff, the QP number must be noted in the affected consumer's clinical record and in the clinical incident management system.

Reporting to police does not mean an investigation will automatically take place. Police are responsible for determining whether and how a police investigation will occur when a sexual safety incident has been reported.

Regardless of the outcome of a report to police or a police investigation, the HHS is responsible for following appropriate processes with regards to clinical, disciplinary and other issues that may arise from a reported sexual safety incident.

17.4.1 When services must report to police

Under this guideline, a report to police is indicated when any of the following circumstances apply:

- It is alleged or suspected that a person under 18 years of age has been sexually assaulted (unless Child Safety has already been informed of the incident).
- Sexual misconduct by a member of staff has been alleged.
- There is physical evidence of assault or CCTV footage of assault and/or physical harm has occurred.
- The affected consumer or any other party to a sexual safety incident (such as the consumer's family) wants a report to be made to police. In this case a report should be made even where there is little or no evidence, or the consumer's disclosure or allegation seems implausible.
- The service believes the affected consumer may be under duress not to report to police (for example, from another consumer, a family member or any other person).

If the treating team believes there is a good reason not to report to police in a situation where any of the above circumstances apply, this should be escalated to the consultant psychiatrist and clinical director or senior medical officer for discussion and a decision. The decision made, the rationale and any actions taken must be clearly documented in the clinical record. The decision to report or not to report to police should be discussed with affected consumers. Any other person including a consumer or a family member may decide to make a report to police if they wish.

Even where none of the above circumstances apply, **a report to police can be made by the service, with or without consent from the affected consumer**. If considering reporting without consent, this should be escalated to the consultant psychiatrist and clinical director or senior medical officer for discussion and a decision. Risks and benefits of making the report should be considered, with due regard given to the consumer's human rights and any concerns the consumer may have about reporting to police.

17.4.2 Discussing police involvement with consumers

Where a report to police is to be made, or is being considered, consumers should be informed through an open and transparent discussion. Where appropriate, their family/carer may also be included. This is aligned with supported decision making [15].

- Describe the role of police and the benefits of reporting to police to the affected consumer.
- Provide an opportunity for all involved consumers and their family or carers to ask questions.
- Request the affected consumer's consent to make a police report.
- Where applicable, advise the affected consumer and their family/carer that a report might be made to police without their consent, and the reasons for this (see section 17.4.1 When services must report to police).
- If a consumer wishes to make a report to police themselves, this must be facilitated.
- An affected consumer who does not wish to report to police can choose the Alternative Reporting Option (ARO). This involves completing an online form to provide police with information about what happened, without being involved in a police investigation or the matter going to court. This can be done anonymously if desired. This option is available on the Queensland Police Service website (www.police.qld.gov.au) under the Adult Sexual Assault link. Police will assess the information provided, and may use it when investigating other reported offences of a similar nature.

For assistance in understanding police processes and/or what is involved for consumers when a report to police is made, consult with local police, senior MHAOD service staff or the local sexual assault response service for advice and support. Refer also to the *Queensland Government Interagency Guidelines for responding to children, young people and adults who have experienced sexual assault or child sexual abuse*.

17.4.3 Preserving evidence

Police can provide advice about how to preserve evidence where sexual assault has been alleged. This may include the following [15]:

- Preserve the room or location where the incident is alleged to have occurred.
- If assault is alleged, where possible encourage the affected consumer to avoid showering, washing their hands, rinsing their mouth, brushing their teeth or changing their clothes.
- If the consumer feels compelled to change their clothes before police arrive (or before a forensic medical examination is performed), seal each item of clothing in a separate bag to provide to police, or to accompany the consumer to a forensic examination.
- Locate and secure any CCTV footage and/or body-worn camera images (local procedures should outline how to request this).

- Record the details of all parties including witnesses.
- Staff must ensure personal property retained for evidentiary purposes is stored securely, documented (including chain of custody) and managed in accordance with local procedures.

These steps also apply to any evidence obtained from the accused person or another party. Briefly explain the process of preserving evidence to all parties, and inform them that they have a right to advocacy and support as part of this process.

18 Information, education and training for staff

Services have a responsibility to support workforce capability in promoting sexual health and safety, and in responding appropriately to sexual safety incidents. Staff should have access to the necessary education, training and support to enable them to fulfil their roles in promoting the sexual health and safety of consumers, assessing and responding to risk, and responding to sexual safety incidents.

18.1 Staff induction and orientation

Information about staff roles and responsibilities in assessing and managing consumer sexual health and safety risks, tailored to the relevant service setting, should be part of routine induction and orientation for staff. Information should also be given about managing risks to staff safety in the service environment, and the supports available to staff.

18.2 Ongoing education and training

Services should employ a range of approaches to support education and training relevant to sexual and reproductive health and sexual safety, domestic and family violence, trauma-informed and culturally safe care, and gender-sensitive and neuro-affirming practice. Examples of approaches include:

- regular discussion of identified risks and risk management strategies during staff meetings
- discussion of risk assessment and safety planning for individual consumers during multidisciplinary team review
- provide clear information about local governance procedures and escalation mechanisms
- identify in-service training opportunities. Particularly in high-acuity service settings and/or settings in which staff work in shifts, consider offering training in brief segments that are repeated on different days and at different times
- identify essential information and training for all staff, and more specialised training for specialist positions and senior staff who can provide support and guidance for other staff
- involve relevant local services to help develop workforce capability, for example staff from local sexual assault response services and sexual health services
- seek opportunities for training that is co-designed and/or co-facilitated with Lived Experience (Peer) workers and/or others with a lived experience
- support staff access to relevant other training, such as training in trauma-informed care and in supporting families and carers

- raise awareness about sexual assault, harassment, sexual safety and where to access support by displaying appropriate materials on a notice board, on service intranet pages, and/or in other areas to which staff have access
- provide staff with information regarding external education, training and professional development opportunities, and support access to these opportunities.

18.3 Clinical / professional supervision

Services are responsible for ensuring all staff (including clinical, Lived Experience (Peer), administrative, project and other staff) have access to supervision to assist in the delivery of high-quality care, maintaining professional boundaries, improving consumer outcomes, and supporting staff wellbeing [29], [30]. Refer to the *Queensland Health Supervision guidelines for mental health alcohol and other drugs services* and the related *Peer practice supervision guide - mental health alcohol and other drugs Lived Experience (Peer) workforce*.

18.4 Organisational supports

All staff have a right to be and feel sexually safe at work. All staff should have access to post-incident support, including through the Employee Assistance Program. Staff should be encouraged to seek support if they need it and should have access to information about sources of support.

19 Privacy, confidentiality, disclosure, documentation and record keeping

Everyone who accesses public sector health services has a right to expect that information held about them will remain private. Queensland Health is subject to legislation which sets the standards for how staff collect and handle personal, sensitive and confidential information. Key state legislation includes:

- *Information Privacy Act 2009*
- Part 7 of the *Hospital and Health Boards Act 2011*
- *Public Health Act 2005*
- *Mental Health Act 2016.*

Staff are responsible for protecting personal, sensitive and confidential information. Provisions in the legislation and in relevant information sharing agreements allow for sharing or releasing information in circumstances where it is necessary for consumer care or required under law.

When assessing risk, planning for sexual safety, responding to a sexual safety incident and documenting the incident, staff should be guided by the following:

- Collect only the information that is necessary. Collect personal information from the consumer directly wherever possible, and take steps to notify a consumer about what information you are collecting, why (including whether you have a lawful requirement to collect it) and what you intend to do with the information.
- Document the incident and any actions taken as clearly as possible, including the consumer's own words where possible, as well as observations from staff or others, and the names of all persons to whom the incident was reported. Use objective and non-judgemental language.

- In some instances, there may be a legal duty to produce documents (for example, during investigations and other legal proceedings). Comprehensive documentation and maintenance of accurate records is imperative to ensure an appropriate response, effective management and service accountability.
- Consider using CIMHA alerts to support safe, appropriate and timely responses to sexual safety issues. CIMHA alerts which may support sexual safety risk mitigation include *inappropriate sexual behaviour*, *cultural needs* and *disability*.
- Access to, and disclosure of, personal information regarding a sexual safety incident should be limited to people directly involved in the case, unless the disclosure is required or permitted by law or enabled through an information sharing agreement such as a memorandum of understanding.
- Where confidential information is disclosed, it is important that only information that is relevant to the particular circumstances be disclosed (i.e. the minimum necessary to satisfy the particular requirement).
- Documentation and records are to be prepared and kept in accordance with legal and Queensland Health requirements, including obligations relating to privacy and confidentiality.

For further information about personal information, health records, privacy and Right to Information, refer to:

- the Queensland Health webpage on information sharing in mental health alcohol and other drugs services (access directly via Information sharing | Queensland Health or go to www.health.qld.gov.au
- and type ‘Information sharing in mental health’ into the search pane).
- HHS Decision Maker and Privacy and Confidentiality Contact Officers
- the Australian Charter of Healthcare Rights.

20 Prompt sheets

On the following pages are two prompt sheets designed to assist MHAOD services to respond to the sexual health and safety needs of consumers:

1. Prompt sheet 1: Responding to sexual safety incidents.
2. Prompt sheet 2: Diverse populations with specific sexual health and sexual safety needs.

Prompt sheet 1: Responding to sexual safety incidents

Considerations	Have these prompts been considered when responding to sexual safety incidents?
Establishing safety after an incident	Have senior staff been informed of the incident? Has everyone been supported to move to a safe location? Have urgent medical needs been addressed? Have specific support needs been considered (e.g. communication supports, sensory needs)? Is an immediate report to police or Child Safety needed?
Providing care following an incident	Has psychological support been offered? Who is best situated to provide this support? Is a medical examination indicated and does the person consent? Is a forensic examination indicated? Have options for forensic examination been offered to the consumer? Does a psychiatric review need to be arranged?
Safety planning	Have involved consumers (including witnesses) 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?
Advocacy, counselling and support	Have all parties had the opportunity to be supported to make decisions that affect them? Has the affected person been informed about the support available from the local sexual assault response service? Has a referral been offered? Have legal and non-legal advocacy options been offered to all parties? Could Lived Experience (Peer) workforce staff be engaged to support accessing advocacy services?
Communication	Has the relevant family member, carer or supporter been contacted? Can the consumer make this contact themselves? How can the treating team support this process? If consumers do not wish to inform family, a carer or a supporter, has consideration been given to whether the service is obliged to contact without consent (for example, if the consumer is under 18 or there is ongoing risk)? Could sharing this information involve risk to the consumer (for example, family violence, cultural norms)? Has an open disclosure process commenced? Has information about the incident been included in the discharge summary? Has recovery-oriented, culturally safe and accessible language been used in all communication?
Reporting and documenting	Has the incident been recorded on the clinical incident management system? Has the incident been thoroughly and accurately documented in all relevant clinical records? Has the matter been escalated within the service, in line with local protocols? Does the incident need to be reported to the Chief Psychiatrist or Office of the Health Ombudsman?
Queensland Police and Child Safety	Does the affected person or any other person want to report the matter to the police? How can the affected person be supported to make the report to police? Does the service have a responsibility to report the matter to police? Has the report been made and the QP number documented? Would contacting police for advice be beneficial? Could advice and support from local Queensland Health child protection staff be beneficial? For a contact list and additional resources refer to the Queensland Health intranet (QHEPS) Child Protection Policy homepage (or type 'child protection policy' into the QHEPS homepage) Does the service have a responsibility to report the matter to Child Safety? Has the report been made and documented?
Supporting staff	Have staff involved been offered support? Are affected staff members able to finish their shift? Have options been considered for post-incident support?

Adapted, with permission, from Victoria's 2025 Chief Psychiatrist guideline *Improving Sexual Safety in Mental Health and Wellbeing Services*.

Prompt sheet 2: Diverse populations with specific sexual health and sexual safety needs

MHAOD services are responsible for responding to the diverse needs of consumers. This section outlines some key considerations, suggested service responses and support options for a range of diverse population groups.

This is not an exhaustive list. In addition to the support services listed in this section, refer to:

- section 5.2.2 (subsection on referral to specialist services) for sexual and reproductive health services
- section 11.5 for sexual assault support services and legal/advocacy services.

Acronyms used in this section			
DFV	domestic and family violence	QCS	Queensland Corrective Services
GP	general practitioner	QH	Queensland Health
IDD	Intellectual and Developmental Disability	STI	sexually transmitted infection
PHN	Primary Health Network	BBV	blood-borne virus

Population group	Key sexual health & safety considerations	Service response & support options
Aboriginal and Torres Strait Islander peoples	• Higher vulnerability to sexual violence (particularly women and girls) • Cultural taboos may prevent discussion of sex, sexuality or gender. • Fear of shame, loss of cultural and psychological safety • Language or hearing barriers may impede communication	• Partner with Aboriginal and Torres Strait Islander health workers and community-controlled organisations • Use accredited interpreters and adopt trauma-informed, culturally safe practice • Link with community supports **Other supports/resources:** • QH First Nations Health Office • Aboriginal and Torres Strait Islander health workers / mental health workers and liaison officers • QH Deafness and Mental Health Consultation Service
People living in rural and remote communities	• Barriers to attending in-person sexual health care and post-incident support • Confidentiality concerns in small communities • Elevated risk of domestic and family violence • Risk of localised STI outbreaks	• Offer telehealth and outreach appointments • Partner with local GPs, PHNs and sexual and reproductive health clinics • Emphasise confidentiality and continuity of care **Other supports/resources:** • Domestic and Family Violence (DFV) information and resources for health workers • Royal Flying Doctor Service Queensland

People from culturally and linguistically diverse (CALD) backgrounds	• Past trauma or displacement • Language barriers • May have limited trust in systems • May have limited sexual health knowledge	• Provide accredited interpreters (do not use family/friends) • Confirm informed consent • Build rapport using culturally responsive approaches • Screen opportunistically for endemic infections **Other supports/resources:** • Queensland Transcultural Mental Health Centre • Ethnic Communities Council of Queensland (www.eccq.com.au) • Refugee Health Network Queensland (www.refugeehealthnetworkqld.org.au) • QPASTT (https://qpastt.org.au/) • Local cultural support services
Children and young people (under 18 years)	• Possible history of abuse • Increased vulnerability to sexual harm • Developmental differences in behaviour and capacity to consent. • Limited sexual health knowledge	• Use age-appropriate risk assessment • Maintain Child Safe Standards • Engage carers with consent • Create child-safe and trauma-informed environments **Other supports/resources:** • QH Child and Youth Mental Health Services (CYMHS) • QH Child Protection staff • Child Safety • True Relationships & Reproductive Health (www.true.org.au): Traffic Lights • Child advocacy centres
Adolescents and young adults (16-25 years)	• Privacy and autonomy needs • May lack accurate sexual health knowledge • Peer influence and substance use may increase risks to sexual health and sexual safety	• Promote respectful relationships and consent education • Normalise sexual health discussions • Provide confidential support and opportunistic screening for STI/BBV **Other supports/resources:** • True Relationships & Reproductive Health (www.true.org.au): Traffic Lights • Headspace centres (www.headspace.org.au)
Older persons (65 years and older)	• Sexual health and sexual safety often overlooked • Increased risk of assault in care settings • Increased risk of unsafe sexual practices	• Incorporate sexual health into routine assessments • Use sensitive approaches considering cognition, medication, and mobility • Screen for elder abuse • Screen for STI/BBV and other medical issues

	• Barriers to reporting (physical/cognitive)	• Adjust medications where relevant **Other supports/resources:** • Queensland Elder Abuse Prevention Unit (www.eapu.com.au) • Aged Care Quality and Safety Commission (www.agedcarequality.gov.au) • Seniors Enquiry Line Queensland 1300 135 500
People in custodial settings	• Past trauma or displacement • Increased exposure to sexual assault, unsafe sex, injecting drug use and STI/BBV transmission • May have limited sexual health knowledge	• Collaborate with Queensland Corrective Services for medical and psychosocial support • Implement harm-reduction and trauma-informed care • Ensure access to sexual health follow-up post-release **Other supports/resources:** • QH-QCS Information sharing agreement • QH Prisoner Health Services • QH Forensic Mental Health Service
People who are Deaf or hard of hearing	• Past trauma or sexual assaults under-reported • Language or hearing barriers may impede communication • May lack accurate sexual health knowledge	• Provide accredited interpreters (do not use family/friends) • Confirm informed consent • Offer culturally responsive, trauma-informed approaches • Screen opportunistically for endemic infections **Other supports/resources:** • QH Deafness and Mental Health Statewide Consultation & Liaison Service (ph. 07 3317 1080, text 0427 598 076) • QH Interpreting and translating guidelines and resources • Deaf Connect (www.deafconnect.org.au)
People who are gender diverse, non-binary or LGBTIQ+	• May experience stigma, discrimination and barriers to care • Higher vulnerability to sexual violence or unsafe sexual practices	• Deliver inclusive and affirming care • Check and use preferred pronouns • Be alert for DFV indications • Provide targeted sexual health education and STI/BBV screening **Other supports/resources:** • Queensland Council for LGBTI Health (www.qc.org.au) • Open Doors Youth Service (LGBTIASB+) (www.opendoors.net.au) • Domestic and Family Violence (DFV) information and resources for health workers • Gender Service (18+) (Metro North HHS)

People with physical, intellectual or developmental disability	• Past trauma or possible history of abuse • Experience communication barriers • Lack of accessible sexual and reproductive health education • High risk of exploitation • Diagnostic overshadowing impacts recognition of treatable conditions and symptoms of trauma or mental health issues	• Enable supported decision-making • Use accessible communication • Involve support persons where appropriate and focus on autonomy and consent • Be aware of potential diagnostic overshadowing • Screen opportunistically for STI/BBV and other medical issues **Other supports/resources:** • WWILD Sexual Violence Prevention Service (www.wwild.org.au) • True Relationships: Looking After Me Program (LAMP) for IDD sexuality education (www.true.org.au) • Queenslander with Disability Network (QDN) • Queensland Centre of Excellence in Intellectual Disability and Autism Health (QCEIDAH) • Specialist Mental Health Intellectual Disability Service (SMHIDS) - statewide • Local QH Mental Health Intellectual and Developmental Disability (IDD) Services
People who are neurodivergent	• Possible history of abuse • Increased vulnerability to sexual harm • Differences in communication, sensory needs, or social understanding • Risk of exploitation and developmental differences in consent and behaviour. • Peer influence and substance use may increase risk	• Use neuro-affirming communication and sensory-aware environments • Use accessible communication and resources (e.g. visual aids and plain language) **Other supports/resources:** • WWILD Sexual Violence Prevention Service (www.wwild.org.au) • True Relationships: Looking After Me Program (LAMP) for IDD sexuality education (www.true.org.au) • Queenslander with Disability Network (QDN) • Queensland Centre of Excellence in Intellectual Disability and Autism Health (QCEIDAH) • Local QH Mental Health Intellectual and Developmental Disability (IDD) Services
People experiencing homelessness or housing insecurity	• Limited access to safe environments • Possible history of abuse • Increased risk of assault and transactional sex	• Collaborate with specialist homelessness services • Offer flexible, outreach-based care • Ensure follow-up for infections or post-assault treatment • Be aware of potential diagnostic overshadowing • Screen opportunistically for STI/BBV and other medical issues **Other supports/resources**: • Homelessness Hotline 1800 474 753

		• Ask Izzy online directory (www.askizzy.org.au) • QH MHAOD Homeless Health Outreach teams
Women	• Higher vulnerability to sexual violence across lifespan, including DFV • Hormonal stages affect sexual health (e.g. postpartum, perimenopause, menopause, effects of hormonal contraceptives)	• Enable choice of staff (e.g. gender-congruent) • Opportunistic STI/BBV checks; contraception counselling • Be alert for DFV indications **Other supports/resources:** • Womensline: 1800 811 811 • DV Connect (www.dvconnect.org) • Domestic and Family Violence (DFV) information and resources for health workers • Women's Health and Equality Queensland (www.wheq.org.au)

Continuous improvement

Quality and safety improvement processes in MHAOD services support the delivery of high-quality clinical care. This guideline is aligned with a number of the Queensland Safety Priorities in Mental Health Alcohol and Other Drugs Care including Priority 1: Partnering for improved safety, which includes sexual safety. MHAOD services are encouraged to apply the Queensland Safety and Quality Improvement Framework: Mental Health Alcohol and Other Drugs Care in achieving and maintaining a learning culture to drive safety and quality improvement.

Partnering with consumers

Consumers are active partners in their care and should be meaningfully involved in care decisions. Services are to support choice and independence by providing clear, timely information and encouraging consumers, families and carers to ask questions and engage in open conversations about treatment. Consumers must be informed of their rights to privacy and confidentiality, including any limitations. Staff are responsible for communicating in accessible, consumer-centred ways and for checking understanding throughout the care process.

Trauma-informed care

Trauma-informed approaches are central to preventing and responding to sexual safety incidents. By recognising the impacts and signs of trauma, this approach to care aims to restore safety and personal agency while avoiding retraumatisation. Trauma-informed care places strong emphasis on physical and emotional safety, shared decision-making, transparent practices, Lived Experience (Peer) support, and respect for culture, language, gender, and other individual needs and preferences. [31]

Human Rights

Respect for human rights is fundamental to supporting the recovery of people living with mental illness and alcohol and other drugs disorders. The *Human Rights Act 2019* requires that proper consideration is given to human rights when making a decision that may affect or limit an individual's human rights. The provision of treatment and care in MHAOD services must be in keeping with human rights considerations as per the *Human Rights Act 2019*, including, but not limited to, access to health care, respect, privacy, cultural considerations, and humane treatment.

Considerations for Aboriginal and Torres Strait Islander consumers and families

When working with Aboriginal and Torres Strait Islander consumers and their families and communities, it is essential to adopt a culturally safe, trauma-informed and respectful approach to the provision of health care. At all stages of engagement, consider whether the consumer may benefit from the involvement of an Aboriginal and Torres Strait Islander Mental Health Worker.

Some specific considerations related to sexual health and sexual safety for Aboriginal and Torres Strait Islander consumers can be found in section 20 Prompt sheet 2: Diverse populations with specific sexual health and sexual safety needs.

Diversity considerations

Effective health care requires recognising and respecting the diversity of consumers, including differences in culture, language, age, disability, religion, sexuality, gender identity and geographic location when providing health care. At all stages of engagement, consider whether input is needed from health and/or other agency providers with identified roles who could appropriately and respectfully engage and provide support. For specific considerations, suggested service responses and support options for a range of diverse population groups, refer to section 20 Prompt sheet 2: Diverse populations with specific sexual health and sexual safety needs.

Glossary

Term	Definition
Accessible language	Written, spoken, and digital communication that is understandable and usable by people who speak different languages or have varying levels of language proficiency. Language accessibility includes providing translations, interpreters, simplified language, captioning, and alternative communication formats to ensure equitable access.
Accused/suspected person	A person against whom an allegation or report has been made regarding a breach of sexual safety, or who is otherwise suspected of a breach of sexual safety. See also *Perpetrator (alleged/suspected)*.

Affected consumer / affected person	A consumer or other person who has disclosed, alleged or reported a sexual safety incident, or who is otherwise suspected or known to have experienced a sexual safety incident.
Capacity	A person with capacity can understand, retain, and weigh up the information relevant to a decision, communicate their choice, and make the decision freely and voluntarily. Capacity is decision- and time-specific and can fluctuate. The presumption under Queensland law is that every adult has capacity unless proven otherwise. Adolescents under the age of 18 may have capacity (known as Gillick competence). For people with intellectual disability, capacity assessments consider their ability with supports such as simplified language, visual aids, or communication assistance.
Consent (to treatment)	Consent to treatment refers to a person's agreement to the provision of a public sector health service. Consent to treatment requires that a person has the capacity (ability) to understand their illness, the nature, purpose, benefits, risks, alternatives, and consequences of treatment, can make a decision about the treatment, and communicate that decision. Consent must be informed, voluntary and supported as needed. People with an intellectual disability have the right to make their own decisions about treatment and can be supported through accessible communication, additional time, or alternative formats. The *Mental Health Act 2016* provides that a person may have capacity to consent even if they decline treatment, and may receive support in making decisions.
Consent (sexual)	Sexual consent refers to a person's agreement to witness or participate in a sexual act. Sexual consent requires that all parties involved in a sexual act must ask for consent, give consent clearly through speech or body language, fully understand what they are agreeing to, have the capacity to consent, and have not been coerced, threatened, pressured or tricked into it. Consent is an ongoing process and can be withdrawn at any time. A person cannot give consent to a sexual act if they are asleep or unconscious, or under 16 years of age. A person might not have capacity to give consent due to an intellectual, psychiatric, cognitive or neurological condition, or if intoxicated by drugs or alcohol.
Consumer	A person who is receiving or seeking care from public mental health, alcohol and other drugs (MHAOD) services. Also - 'affected consumer', 'affected person' and 'victim-survivor' to indicate a consumer who has disclosed, alleged or reported a sexual safety incident, or who is otherwise suspected or known to have experienced a sexual safety incident. See also *Victim-survivor*.
Disability	Disability includes physical, intellectual, psychiatric, sensory, neurological and learning disabilities, and chronic illnesses, as recognised in the *Disability Discrimination Act 1992* (Aust.) and the *Disability Services Act 2006* (Qld).
Easy Read	A form of accessible language in which information is presented using a clear and concise style of writing that conveys core messages using plain English, supported by visual aids such as pictures, symbols and diagrams. This format is designed to assist people to understand important information when they have low literacy, a cognitive or intellectual disability, or are a non-native English speaker. See also *Accessible language*.
Intellectual and Developmental Disability (IDD)	Refers to conditions characterised by significant limitations in both intellectual functioning and adaptive behaviours, with onset during the developmental period.
Lived Experience (Peer) workers	Identified positions within the Queensland Health workforce that provide professional support and advocacy for consumers. Peer workers have a personal lived experience of mental illness and/or alcohol and other drug problems and recovery, and/or caring for someone with a lived experience of mental illness and/or alcohol and other drug problems and recovery. Peer workers are often integrated into multidisciplinary teams.
MHAOD services	Refers to Queensland Health mental health, alcohol and other drugs services.
Neurodivergence	Refers to naturally occurring variation in cognitive functioning, including (but not limited to) autism, ADHD, dyslexia, dyspraxia, and other neurodevelopmental differences.

Perpetrator (alleged/suspected)	A person against whom an allegation or report has been made regarding a breach of sexual safety, or who is otherwise suspected of a breach of sexual safety. See also *Accused/suspected person*.
QP number	The unique reference number assigned by Queensland Police to every recorded incident. The number starts starting with 'QP', followed by the two-digit year and an eight-digit number (e.g., QP2612345678). The QP number should be quoted in communication with police about specific cases, as it identifies the case in the QPRIME system.
Safety planning	A structured, collaborative process between a consumer and MHAOD service staff to address risks to sexual safety. This may include identifying personal warning signs and triggers, coping strategies, supports, and actions that can help keep the person safe. During admission to an inpatient setting, this should include consideration of bed location and the areas within the ward best able to support the consumer's safety.
Sexual activity in MHAOD service settings	Sexual activity refers to any activity of a sexual nature (including touching, intercourse, oral sex) that occurs between people, in a location that is within or on the grounds of a mental health alcohol and other drugs facility or service, including hospital-based, community-based, inpatient, residential and outpatient services.
Sexual and reproductive health	A state of physical, emotional, mental and social wellbeing in relation to sexuality (not merely the absence of disease, dysfunction or infirmity).
Sexual assault	Any unwanted sexual act that is forced on a person without their consent, including where intimidation, physical force, or coercion are involved. Instances of sexual abuse (for example, child sexual abuse) are included under the term sexual assault.
Sexually disinhibited behaviour	Sexual disinhibition involves an impaired ability to restrain sexual impulses, and presents as poorly controlled behaviour of a sexual nature where sexual thoughts, impulses or needs are expressed in a direct or disinhibited way, such as in inappropriate situations, at the wrong time or with the wrong person.
Sexual harassment	Any unwelcome conduct of a sexual nature that is carried out to offend, humiliate or intimidate another person, or where it is reasonable to expect the person targeted might feel that way. This includes sexual harassment via a phone, smart device or the internet, such as unwanted sexting and image-based abuse (sending intimate images of someone without their consent or threatening to do so).
Sexual safety	Being and feeling safe from any unwanted behaviour of a sexual nature, including sexual harassment and sexual assault, sexual language and observing sexualised behaviour.
Sexual safety breach	See *Sexual safety incident*
Sexual safety incident	Any witnessed, suspected, disclosed or alleged occurrence of sexual assault, sexual harassment or sexually disinhibited behaviour. Also, any sexual activity in MHAOD service settings. This does not apply to private masturbation.
Sexual violence	Sexual activity that occurs where consent is not freely given or obtained, is withdrawn or the person is unable to consent. This includes sexual assault, sexual harassment, sexual abuse and technology-facilitated sexual abuse and harassment.
Supported Decision-Making	Assistance provided to people with impaired decision-making capacity to enable them to make their own informed choices, as promoted in disability and mental health frameworks.
Victim-survivor	A consumer who has disclosed, alleged or reported a sexual safety incident, or who is otherwise suspected or known to have experienced a sexual safety incident. See also *Consumer* (*affected consumer* or *affected person*).

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