

**RESPONDING TO AN
ALLEGATION OF SEXUAL
ASSAULT DISCLOSED
WITHIN A PUBLIC
MENTAL HEALTH SERVICE**

February 2012

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Foreword

It is with great importance that I launch *Responding to an Allegation of Sexual Assault Disclosed within a Public Mental Health Service* (hereafter ‘the guidelines’), for staff of public mental health services in Western Australia.

Sexual assault and sexual abuse are traumatic events that can have long-term negative health and psychosocial effects. Literature, research and clinical experience in both the sexual assault and mental health fields demonstrates a clear link between sexual violence and mental health issues. Individuals with a history of sexual violence (childhood sexual abuse and/or sexual assault) often present to mental health services with various mental health issues. In addition, research indicates that clients with significant mental health concerns are at a heightened risk of being sexually assaulted.

People who experience sexual assault and sexual abuse often feel a range of emotions including shock, fear, guilt, shame, depression and an inability to trust others. The social stigma attached to sexual assault and sexual abuse may heighten these feelings and increase the trauma that is experienced. One worryingly common response by victims of sexual assault is an inability to disclose the assault to anyone, depriving them of the support they need to heal.

WA Health recognises the need for guidelines that can assist in addressing the impact of alleged sexual assaults disclosed within a mental health service. Such guidelines are essential to assist staff to respond in a consistent, effective and timely manner to a disclosure of an allegation of sexual assault; to support all individuals involved; and to minimise the impact of such an event on clients’ mental health.

These guidelines have been developed in response to an articulated need from mental health and Sexual Assault Resource Centre (SARC) staff for a clear process to be established and documented to address the disclosure of an allegation of sexual assault within mental health services. Although the guidelines are intended to assist staff in responding appropriately and with

sensitivity to the disclosure of recent sexual assault, the guidelines also address prior sexual assault and the procedures staff should take.

The guidelines focus on responding to the needs of the individual whilst contributing to a safe mental health service environment, and providing relevant and expected treatment to all individuals involved.

I would like to thank those individuals within the working group which contributed to the development of the guidelines and provided valuable input, advice and expert knowledge.

In addition, I would like to acknowledge and thank Dr Aaron Groves and Queensland Health for granting permission for these guidelines to be based on similar guidelines produced by Queensland Health - *Responding to Sexual Assault and Promoting Sexual Safety within Queensland Health Inpatient Mental Health*.

I strongly encourage staff to utilise the information covered within these guidelines in their responses to a disclosure of sexual assault.

Kim Snowball

Director General

WA Health

The guidelines will be available on:

Department of Health: www.health.wa.gov.au

Women and Newborn Health Service: www.kemh.health.wa.gov.au

WA Country Health Service www.wacountry.health.wa.gov.au/

Mental Health Commission: www.mentalhealth.wa.gov.au/Homepage.aspx

or (08) 9420 7277

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Section 1: Introduction

Sexual assault is a crime of violence, where a person uses their power and control to dominate another. Sexual assault can be any sexual behaviour or act that is threatening, violent, forced, coercive, or exploitative and to which a person has not given or was not able to give consent. Sexual assault can take many forms including:

- Being forced to masturbate or watch another masturbate;
- Being forced, coerced, or bribed to view pornographic images;
- Being forced to give or receive oral sex;
- Being forced to perform sexual acts on themselves or others; and
- Sexual penetration of a person by penis, object, or other part of a body into the vagina, anus or mouth.

Within these guidelines, the following terminology will be used:

- Client: the individual who is a 'patient', 'consumer' and/or 'user' of a Department of Health Western Australia Mental Health Service;
- Alleged victim: the person who is alleging the sexual assault; and
- Alleged perpetrators: the person or persons who is/are alleged to have committed sexual assault.

The specific circumstances where these guidelines apply are:

- When the allegation of sexual assault occurred within a mental health inpatient service; or
- When the allegation of sexual assault occurred during times of receiving mental health services as an outpatient, such as within a day hospital or within the community, whether for acute care or extended treatment.

The process for managing alleged victims under 18 years of age is comprehensively covered in section 4.7.

The guidelines have been developed by a working group consisting of representatives from WA Health Mental Health Services, including: Child and

Adolescent Mental Health Services (CAMHS), the Child Protection Unit (CPU), Adult Mental Health Services (AMHS), Sexual Assault Resource Centre (SARC), Statewide Indigenous Mental Health Service (SIMHS), Office of the Public Advocate, Office of the Chief Psychiatrist, and representatives from consumer and carer groups and the forensic psychiatry sector.¹ The working group also undertook consultations with other key stakeholders and agencies throughout the duration of the project.

1.1 Rationale

The underlying principle for these guidelines is to minimise the impact on clients' mental health by assisting staff to respond in a consistent manner to a disclosure of an allegation of sexual assault.

A large amount of research, literature and clinicians' experiences in both the sexual assault and mental health areas demonstrates a clear link between sexual violence and mental health issues. Individuals with a history of sexual violence (childhood sexual abuse and/or sexual assault) often present to mental health services with various mental health issues such as anxiety, depression, suicidality, self-harming, borderline and complex post-traumatic stress disorder. More recently there has also been evidence to suggest individuals who in their adolescence experienced penetrative childhood sexual abuse, were at a greater risk of developing psychotic and schizophrenic syndromes in their adult life (Catajar et al. 2010)².

Additionally, clients with significant mental health concerns are at a heightened risk of being sexually assaulted. For example, Goodman et al (2001)³ found that both men and women with severe mental illness were more likely to have experienced sexual assault compared to the general population.

¹ Refer to Appendix A.

² MC Cutjar, PE Mullen, JRP Ogloff, SD Thomas, DL Wells and J Spataro, *Schizophrenia and Other Psychotic Disorders in a Cohort of Sexually Abused Children*, Arch Gen Psychiatry, vol 67(11), 2010, pp.1114-1119.

³ LA Goodman, MP Salyer, KT Mueser, SD Rosenberg, M Swartz, SM Essock, FC Butterfield, J Swanson, 5 Site Health and Risk Study Research Committee Boston College, The Peter and Carolyn Lynch School of Education, Department of Counselling, Developmental and Educational Psychology, Chestnut Hill, Massachusetts 02467, USA.

1.2 Aim

The development of these guidelines is a significant step in acknowledging the link between sexual violence and mental health issues. The guidelines have been developed to:

Provide a framework for a comprehensive and consistent response to the allegation of recent sexual assault by a person (male or female) who is currently receiving services by a Western Australia (WA) Mental Health Service⁴.

The aim of the guidelines is to outline support for all individuals involved in such incidents, including the alleged victim, the alleged perpetrator, the mental health professionals responsible for the psychosocial, medical, and forensic needs of the clients involved, as well as relevant family members, friends, and carers of the clients.

1.3 Objectives

The guidelines intend to:

- Be informative and easy to use;
- Guide staff in responding appropriately to an allegation of sexual assault disclosed within a mental health service;
- Ensure that there is consistency and efficiency in the response; and
- Ensure better outcomes for clients.

1.4 Target population

WA public Mental Health Services should use the guidelines in conjunction with local service policies and procedures.

⁴ 'Recent' is defined as those sexual assaults that occur within the preceding two-week period. Individuals who disclose an allegation of sexual assault that occurred prior to this two-week period should still be offered the same level of support including a medical examination and psychological support, although the likelihood of forensic detection will be diminished.

Immediate response by mental health service clinicians: A summary

- Ensure the safety and welfare of the client. Assess physical and emotional well-being and respond appropriately.
- Allocate an appropriate staff member to remain with the client to provide support and care.
- Ensure the client's privacy.
- Good communication is vital. Arrange for an appropriate translator or interpreting service for the client if required.
- Advise the client that they are entitled to access a support person of their choice and facilitate contact.
- Advise the client that they are entitled to speak with a doctor, have a general medical examination and receive advice and medical treatments such as contraception and information on prevention of sexually transmitted infections (STI) prevention if appropriate.
- Advise the client that they have the right to a forensic examination and police involvement if they so choose.
- If the client wishes to have forensic evidence collected, a non-treating medical officer should be arranged (not their psychiatrist) to collect same.
- Arrange medical assessments as requested/needed by the client.
- The Sexual Assault Resource Centre can be contacted for advice and to provide a forensically trained medical officer and counsellor to assist with a medical and forensic examination.
- If the alleged perpetrator is a client, staff member, family member, relative or visitor they will require privacy, support and access to assessment and information and their physical and emotional wellbeing must also be considered.
- Where possible the forensic examination and collection of evidence should include SARC.

Section 2: Response to an allegation of recent sexual assault

2.1 Principles

As previously mentioned, there are potentially two situations where mental health service staff may need to support a client who is considering reporting an allegation of sexual assault:

- When the allegation of sexual assault has occurred within a mental health inpatient service; or
- When the allegation of sexual assault has occurred during times of receiving mental health services, such as within the community or a day hospital.

Responding to sexual assault within WA Mental Health Services should be undertaken within a framework consistent with the following overarching principles:

- All clients (the alleged victim and the alleged perpetrator) are to be treated with respect and dignity. They are to be provided with information and support where required in relation to the alleged sexual assault, their mental illness and other areas of their lives;
- Information is to be provided in a manner that addresses issues of equity and access to ensure the individual needs of the client are met in relation to language, culture, age, disability, gender, sexuality and capacity;
- If the client is under 18 years of age, the *Children and Community Services Act 2004* requires doctors, nurses and midwives to comply with mandatory reporting requirements when they have a reasonable belief that sexual abuse of a child has occurred or is occurring;⁵
- Information is to be provided in a way that is non-judgemental, appropriate and clear and sensitive to the needs of the client;
- Safety, physical and psychological needs of all clients are of paramount consideration. It is important to consider the impact of

⁵ <http://mandatoryreporting.dcp.wa.gov.au/Pages/Home.aspx>
For more information about persons aged under 18 years, refer to Table 1 Section 4.7.

the allegation upon others within the service, and to ensure minimal disruption to other clients;

- The client's right to privacy and confidentiality will be respected at all times unless disclosure is required by law;
- The client's informed decision will be respected at every stage of the process unless disclosure is required by law;
- The client's sense of personal control will be supported and encouraged;
- Adequate and appropriate support is to be provided to assist the client in making informed choices and decisions;
- If a clinician has concerns or considers that the client has difficulty making an informed choice, an assessment of capacity should be undertaken by appropriate medical personnel;
- If a client who alleges sexual assault is clinically assessed as unable to provide informed consent for a forensic sexual assault examination, the Office of the Public Advocate (OPA) should be involved; the OPA can be contacted on 9278 7300 or 1300 858 455, or for urgent guardianship matters after hours on 9480 5430;
- The client should be provided with up-to-date and comprehensive information about external service options and access to those services facilitated;
- Comprehensive care management plans are to be developed to ensure that effective and appropriate treatment and health care management is provided in a timely manner;
- All allegations of sexual assault are to be comprehensively documented and accurate records are to be kept in accordance with WA Health requirements;
- Sexual assault is a crime. Involvement of the police must be considered in the event of an allegation of sexual assault. It should be noted, however, that it is not the decision of the mental health

service staff to report the incident to WA Police - this is the decision of the alleged victim; and

- It is imperative that all persons involved in an allegation of sexual assault manage the process as an *allegation*. Any incidents require appropriate investigation, but it should not be assumed that the alleged perpetrator is guilty.

Note: Please refer to Pages 24 and 25 of the Guidelines for occasions when disclosure may be justified when not considered by the client.

2.2 Clinical procedures⁶

In the event of an allegation of a sexual assault occurring within a mental health service, or while a client is receiving a mental health service, staff should undertake the steps outlined below. The following ‘best practice’ procedures have been developed to assist staff in responding to reports of recent or previous sexual assault; as well as to assist the individuals involved, provide information of each stage step by step, and allow them time to understand and consider the information being provided. Clients should be informed and reminded that they are able to discontinue the complaint at any point if they choose to do so.

2.2.1 Care for the alleged victim

- Ensure the immediate safety and welfare of the alleged victim;
- Provide privacy for the alleged victim;
- Allocate an appropriate staff member to remain with the alleged victim and provide appropriate support to minimise the impact of the assault;
- Arrange for the assessment and management of the alleged victim’s physical and emotional wellbeing;
- Ensure that the nurse or clinician in charge is advised of the allegation;
- Determine if the alleged victim requires an interpreter and arrange

⁶ Refer to Appendix D and Appendix E

for an appropriate interpreter to be available throughout the process, including during any medical examination or police interview;

- Advise the alleged victim that they are entitled to access a support person of their choice and facilitate this contact. This person may be a partner, friend, carer, community support worker, nurse, counsellor, family member or advocate;
- All reasonable steps to accommodate the alleged victim's expressed preference for female or male personnel should be considered where possible;
- The nurse or clinician in charge will organise a mental health examination for the alleged victim;
- If it is determined that the alleged victim does not have decision-making capacity, then an appropriate personal representative will need to be located to make decisions on the alleged victim's behalf (see section 4.6 for further information); and
- If it is determined that the alleged victim has decision-making capacity, then advise the alleged victim of their rights and choices in relation to:
 - the involvement of the police (see section 3.5);
 - having a forensic medical examination (see section 2.3.1); and/or
 - having a general medical examination (see section 2.3.2).

2.2.2 Care for the alleged perpetrator

Mental Health Services have a duty of care to the alleged perpetrator if he or she is a patient, staff member, relative or visitor. It is vital that staff ensure that the needs of the alleged perpetrator are taken into consideration, with the awareness that the allegations are yet to be proven. The alleged perpetrator may be an involuntary patient, a voluntary patient, a member of support staff or a member of clinical staff. It is acknowledged that the alleged perpetrator may have a similar set of needs to the alleged victim. Individuals who are accused of sexual assault are likely to

experience significant psychological stress and there is a heightened risk of suicide. The following steps should be taken in caring for the alleged perpetrator:

- Ensure the immediate safety and welfare of the alleged perpetrator and advise them of the allegation in an appropriate manner;
- If the alleged perpetrator remains within close proximity to the victim, allocate a different, appropriate staff member to remain with them and ensure that *their* rights and privacy are not violated in the process;
- Determine if the alleged perpetrator requires an interpreter and arrange for an appropriate person to be available throughout the process, including during any medical examinations or police interviews;
- Provide one-to-one expert support if required;
- Arrange for a mental health assessment and consider the need to increase the security provided to the alleged victim, for example the need to transfer the alleged perpetrator from an open ward to a locked ward;
- Provide ongoing acute risk assessment, including assessing for suicide risk, homicide risk and interpersonal violence risk;
- Advise the perpetrator of their rights in relation to accessing medical advice, appropriate acute forensic testing and legal advice;
- Advise the police if there is reasonable suspicion of impairment to decision-making capacity;
- Provide ongoing support through the days and weeks following the allegation; and
- When allegations are made against a staff member, the staff member should be taken to a private space away from the alleged victim, and provided with information and assistance regarding legal rights and available support and their confidentiality ensured.

It is important that different mental health service staff members are responsible for and provide appropriate support and assistance to the alleged perpetrator and the alleged victim. The same staff member is not to assume responsibility for both individuals.

Staff also need to consider the needs of others involved, including family members and staff. Support for others can include referral to an appropriate agency for information, advice and support on how to deal with the situation. A list of services that offer assistance can be found in Appendix B.

2.3 Medical and forensic considerations

It is important to note that in the event of an allegation of sexual assault, alleged victims should be offered a medical and forensic examination. This should ideally occur immediately after the incident. However, an examination can be performed up to two weeks after the alleged incident.

The following medical and forensic concerns are ideally managed by referral to a specialised service such as the SARC, but may need consideration at a Mental Health Service if:

- There is a long delay in seeing a SARC doctor;
- The client does not want to be seen by SARC; or
- The incident occurs in a regional centre where there is no specialised sexual assault service.

Sexual Assault Resource Centre (SARC) has comprehensive protocols for addressing forensic issues and medical issues such as screening and treating Sexually Transmissible Infections (STIs).

2.3.1 Forensic issues

The timeframe for collecting specimens is short and the requirement to collect specimens needs to be viewed within the context of the wishes of the client and the broader medical and psychosocial needs. A forensic examination will include injury documentation and interpretation and collection of forensic specimens. This role should be provided by a doctor who is not involved in the day-to-day management of the client and is able to remain impartial in performing a forensic examination. Specimen

collection may involve swabbing various body sites in order to collect body fluids such as blood, saliva, semen and other specimens such as hair and finger-nail scrapings. Not all specimen collections may be appropriate for each client. Careful documentation of all actions taken when collecting specimens and performing examinations (including informed consent) is very important. Staff should:

- Advise the alleged victim that they have the right to a choice regarding forensic examination, where evidence can be reported to police, or can be stored for a limited time if they are unsure whether to proceed with a criminal investigation;
- Contact SARC and speak to the duty doctor regarding collecting and maintaining evidence from the alleged victim;
- Be aware of the importance of preliminary forensic specimen collection in an effort to maintain evidence. Preliminary SARC kits are available if required. Staff need to explain to the alleged victim the purpose of avoiding showering, changing clothes, going to the toilet and eating or drinking prior to a forensic medical examination. However, if the client is too uncomfortable or traumatised they may need to wash; this should be respected and supported by staff; and
- Should the alleged victim choose to have a forensic examination, the examination should be conducted by a 'non-treating' medical officer. SARC can provide an impartial medical and forensic service for people who allege recent sexual assault. A SARC counsellor can explain the SARC service to the client and the contact staff member of the service. It is important that contact with SARC be made as soon as possible because, while SARC offers a medical/ forensic service up to two weeks after an alleged assault, some medical and forensic issues require immediate attention.

2.3.2 General medical issues

If the alleged victim does not agree to a forensic examination, then they should be advised that they are entitled to speak with a doctor, have a general medical examination and be provided with advice and preventive

treatment.

The medical examination should address injury, contraception and risk of sexually transmissible infections, and should be performed by a medical practitioner with due regard to the patient's wishes.

2.3.2.1. Injury

Considerations should be given to uncommon but severe general physical injuries such as strangulation, stab wounds, intoxication and head injuries. Genital injuries, although relatively uncommon after a sexual assault, can be severe in prepubescent and post-menopausal women and symptoms of pain and vaginal bleeding should be taken seriously. As anal penetration can result in anal tears, sensitive management in terms of examination will be important in these cases. It should be noted that careful examination and documentation of injuries is important for forensic reasons and, with appropriate consent, should include areas of the body such as the mouth, the inner thighs and inner upper arms.

2.3.1.2 Emergency contraception

Emergency contraception should be considered and given promptly where appropriate. Recommendations are for Levonorgestrel 1500 micrograms (Postinor-1). Emergency contraception is most effective if given as soon as possible within 72 hours from intercourse, but there is some minor benefit beyond this timeframe. Please contact SARC if you require further information on emergency contraception.

2.3.1.3 Sexually Transmitted Infections (STIs)

Baseline investigations should be considered in all cases, but can be simplified for a distressed or ambivalent client. A first void urine and serology can be collected without the requirement of a genital examination. Vaginal and/or anal swabs can be self-collected by the client. The medical practitioner should test for STIs and provide treatment as required. Practitioners are encouraged to contact the on-call SARC medical officer if they require specific information on STI tests and treatments.

2.4 Administrative procedures

- Staff member will report the alleged assault to the nurse or clinician-in-charge.
- The nurse or clinician in charge will report this to the service manager.
- Staff should contact the SARC duty doctor regarding advice for initial collection of forensic evidence, as well as other medical matters.
- Where the alleged victim consents, referrals to SARC should be encouraged and facilitated as soon as possible. SARC can provide the client with crisis counselling and a medical assessment.
- If the alleged victim wishes a police report to be made, they are to be supported in this process.
- Rural and remote considerations: for clients alleging sexual assault within rural and remote or isolated areas, staff should still contact SARC. SARC will assist with providing a list of contacts that may be able to assist with medical and forensic assessment. A non-exhaustive list of potential sexual assault counselling agencies is available at Appendix C.
- Services are obligated to report all allegations of sexual assault to the Chief Psychiatrist.
- In the event that an allegation against a staff member is made, the service manager must report the incident to the appropriate area director of Mental Health Service (or equivalent), and the Corporate Governance Directorate of WA Health. The Corporate Governance Directorate can be contacted on 1800 000 224, emailed at corporate.governance@health.wa.gov.au or faxed to 9222 2779. Corporate Governance will inform the Crime and Corruption Commission (CCC), who will in turn inform the WA Police.

Section 3: Additional clinical and management considerations

3.1 Clinical considerations when managing sexual assault

Clinical considerations should be informed by trauma related matters, such as:

- Experiences of sexual abuse and/or sexual assault; and
- Experiences of domestic or family violence.

As these experiences can have a significant effect on the emotional and physical wellbeing of the client, identifying such experiences is essential in developing appropriate and relevant treatment and care management plans.

Information regarding an individual's experience of past sexual assault and sexual abuse should also be included in assessments of risk and vulnerability. It is imperative that these questions are asked in an appropriate and sensitive manner to reduce further trauma to the client. Clinicians should observe the WA Health confidentiality guidelines. For further information on confidentiality please see Operational Circular OP2050/06 at:

http://www.health.wa.gov.au/CircularsNew/circular.cfm?Circ_ID=12052

The medical practitioner involved should have:

- A knowledge and understanding of the issues and impact of sexual abuse and/or sexual assault;
- A preparedness to respond appropriately and sensitively;
- An ability to demonstrate acceptance, belief and acknowledgment of the client's experience;
- An understanding that it is not necessary to encourage people to go into details about the abuse;
- A scheduled allocation of time to accommodate discussion and minimise interruptions;
- An appropriate and comfortable space that affords privacy;
- An ability to provide follow-up and ongoing support either within the

service or through access to external organisations;

- Knowledge of available support, counselling and referral options;
- A belief and demonstrated validation of the emotions and feelings that the client is experiencing;
- A sensitive and non-judgemental attitude while providing an appropriate level of support; and
- An understanding that regardless of whether staff believe that the client's disclosures may be a result of their mental illness - for example the client may be experiencing delusions - the emotional and possibly physical distress the client is experiencing is, for the client, very real. All disclosures of sexual assault and/or sexual abuse should be responded to appropriately and sensitively.

All disclosures should be documented appropriately. A note should be made in the clinical medical file regarding the alleged sexual assault. Detailed information pertaining to the alleged sexual assault should be kept and maintained separately from the client's medical file as per the Western Australian Health Complaints Management Policy.⁷ However, a note should be made in the clients' notes about the existence of this separate confidential file.

Some clients may choose not to answer questions in relation to these areas. In these instances staff should:

- Respect and document the client's decision;
- Not pressure the client to make a disclosure;
- Not assume that the client has not had these experiences if they choose not to answer the questions; and
- Support clients appropriately through this assessment process, as this will demonstrate a willingness to listen, believe and respond to these issues if and when the client chooses to disclose them.

⁷ Refer to Appendix F

3.2 Management of sexual assault victims within an inpatient unit

The experience of accessing an inpatient mental health service for any client may impact on that client's sense of wellbeing and emotional and physical safety. Clients with a history of sexual assault and/or sexual abuse may be especially vulnerable to additional traumatic experiences simply from the routinely occurring treatments and events within mental health services.

With this in mind, staff should be guided by the following:

- Be aware of triggers that may be distressing for the client - including those that may occur during the routine treatment of the client's mental illness. The person may experience emotionally and physically disturbing memories, nightmares or flashbacks that may contribute to the client's feelings of vulnerability, emotional distress and/ or anxiety. Some examples include:
 - Being an involuntary patient and requiring restraint for the purpose of administering medication;
 - Requiring assistance and support with hygiene and other personal needs;
- Being aware of times when a client may be at increased vulnerability to experiences of sexual assault, for example in the shower and bathroom areas, their own room or in secluded areas of the service;
- Providing the client with a bed that is as near as is practicable to the nurses' station/area; and
- Being aware of the clients' increased vulnerability between scheduled observations.

Where the sexual assault is alleged to have taken place within the same mental health service, staff should be guided by the following:

- Ensure the client is not provided with the same room and/or bed where a previous sexual assault has occurred;
- Where relevant, implement strategies to ensure that the alleged offender is not accommodated in the same area to reduce the client's anxiety and the likelihood they may encounter the alleged offender; and
- If available, the option of transferring to another service or area should be discussed with the client.

3.3 Repeat allegations of sexual assault

Some clients who present at mental health services are subjected to repeated assaults, as may be in cases of family and domestic violence. People who have previously been victims of sexual assault may have an increased vulnerability to future assaults and should be provided with appropriate psychosocial support and timely medical and forensic responses.

Occasionally, repeated false allegations of sexual assault occur. These situations are usually well documented by mental health and sexual assault agencies. A routine forensic response is not best-practice management as it can reinforce inappropriate behaviours and distract from providing medical and psychosocial support. These presentations are likely to involve complex issues, and are best managed on a case-by-case basis with an individual management plan formulated by a considered team approach.

Repeated allegations of sexual assault may occur in the context of ongoing psychosis, severe borderline or other personality disorder and intellectual disability. In these cases the possibility of a false allegation needs to be balanced against the understanding that people with a mental illness can be highly vulnerable to sexual assault. Suspected repeat allegations without adequate basis need to be referred to a senior clinician/team for a documented case discussion.

3.4 Clients who are psychotic or display acutely disturbed behaviour

Acutely agitated or disturbed psychotic clients who allege a recent sexual assault present a complex management dilemma. In general, medical and

psychiatric therapeutic care should take priority over forensic procedures such as specimen collection. A forensic sexual assault examination can be conducted as soon as the person is medically stable and able to give informed consent (or a guardian can give informed consent), although the delay may lead to some loss of evidence. These issues can be discussed with the SARC doctor who can assist with information about preliminary forensic specimen collection to prevent loss of forensic evidence in case of a delay due to the severity of a mental illness.

It must be noted that prosecution in cases of an allegation of sexual assault in which the alleged victim was experiencing an acute psychotic illness at the time of the alleged sexual assault is potentially very difficult. This does not mean however, that clients should not be provided with the opportunity to have their allegation investigated.

3.5 Involvement of WA Police

It is important that, in the event of an allegation of sexual assault by an individual over 18 years of age, any reporting to the WA Police be the decision of the alleged victim or where they are regarded as being unable to make a decision, the appointed guardian. Staff may assist in facilitating the report with the permission of the victim; however it is not the decision of the MHS staff member(s) to report the allegation to WA Police. The act of MHS staff reporting to WA Police without the approval of the victim may constitute a breach of confidentiality and can potentially lead to action taken against the staff member or the MHS where the staff member is employed (in some circumstances disclosure may be justified in the public interest - see below).

In the event of the MHS staff member assisting or facilitating the report to WA Police, information should only be disclosed in accordance with the written consent of the alleged victim.

If the alleged victim is undecided about whether or not to proceed with legal action, advice can be sought from SARC regarding the implications of whichever decision is made.

When police attend the mental health service, police and the involved staff

of the mental health service should operate in a collaborative manner, and ensure the confidentiality for both the alleged victim and the alleged perpetrator. When requesting police attendance on behalf of the alleged victim, it is useful for staff to ask that police officers be dressed in plain clothes rather than a uniform to assist with maintaining confidentiality.

If the alleged victim does not wish to report the matter to the police but staff think the matter should be reported in the public interest, then disclosure to WA Police can be justified in some situations. Staff should always seek legal advice prior to disclosure to WA Police in the public interest. Legal advice can be sought from the Legal and Legislative Services (L&LS) Directorate of WA Health. The L&LS Directorate can be contacted on 9222 4038 or emailed on legal.services@health.wa.gov.au

Health professionals are not legally required to assist the WA Police with their enquiries by answering questions, providing witness statements, or preparing medical reports or other documentation not already in existence in relation to allegations of sexual assault that occur to people over the age of 18 years. However, this should not discourage staff from cooperating with Police where appropriate.

In WA, an offence is committed only where a person takes active steps to prevent or obstruct the investigation of an offence.

3.6 Sexual contact between staff and clients

At no time is it acceptable for a staff member employed in a mental health service, regardless of the position they hold, to engage in sexual contact with clients, irrespective of whether the relationship was initiated by the client or the staff member, and whether it was considered consensual.

The behaviour of all employees of WA Health should reflect that which is outlined in *WA Health Code of Conduct*, the *WA Code of Ethics* and the *WA Health Misconduct and Discipline Policy* (2006) which can be found in Appendix F

In addition, the behaviour of employees of the DOH should adhere to the *Public Sector Management Act 1994*. Nurses should refer to the Nurses and Midwives Board of Western Australia publication *Boundaries for Therapeutic*

Relationships. This information is available by contacting the Australian Health Practitioners' Regulation Agency (AHPRA) on (08) 9421 1100.

Section 4: Diverse needs

Mental health services are required to respond to the diverse needs of all clients in the provision of and access to appropriate services. It is important to be aware of diversity, based on culture, language, disability, religion, sexuality or geographic location and how these differences can inhibit access to and use of appropriate services. Procedures need to be flexible in terms of a client's diverse needs not only when responding to allegations of sexual assault but in general health care management.

4.1 Aboriginal and Torres Strait Islander people

Service provision must respect the cultural, religious and language needs of the client. Clients should be advised of their right to access Aboriginal interpreters, Aboriginal Mental Health Liaison Officers (AMHLO) or equivalent. If interpreters or AMHLO's are requested, they should be provided during all stages of the process. Interpreters for the Kimberley region may be booked through Kimberley Interpreting Service (KIS) (08) 91693161, or an Aboriginal Mental Health Liaison Officer can be used for other areas/regions, depending on where the Aboriginal and Torres Strait Islander (ATSI) person is from. In the interest of ensuring client confidentiality, clients should be provided with the option of either a telephone interpreter or a local on-site interpreter (this can sometimes be the AMHLO or negotiated by the AMHLO).

When working with clients from diverse ATSI language/skin groups, consideration must be given to the diversity of the ATSI culture, values views and expectations. ATSI people may have unresolved grief surrounding the forced removal of their children. The impact of forced removal has resulted in problems with identity, acceptance, parenting and Trans-generational Trauma. As this information may not yet have been disclosed to family, spouses/partners, sensitivity must be exercised upon a client's disclosure of these unresolved traumatic events as there is potential threat of payback/consequences to the client and their family.

Additionally, Aboriginal people may have past experiences that could impact

on their ability to trust government services and which could negatively affect their interaction with current medical staff. Past experiences of trauma have the potential to hinder the relationship with services support, if those experiences have not been disclosed or understood by the service provider.

For additional information regarding promoting, improving and maintaining the mental health of ATSI people, staff should refer to their Indigenous Mental Health Liaison Officer, or the Statewide Indigenous Mental Health Service on 08 9347 6866.

4.2 People from culturally and linguistically diverse backgrounds

Service provision must respect the cultural, religious and language needs of the client. Clients should be advised of their right to access interpreters. If interpreters are requested, they should be provided during all stages of the process. Where communication in English is difficult, professional, accredited interpreters, and/or appropriate bilingual/bicultural support persons should be used to assist in providing the client with information which enables them to make informed decisions about their health care and their legal rights. Staff should refer to local service policies or WA Health's website: www.health.wa.gov.au for information.

Interpreters may be booked through Translating and Interpreter Services (TIS) on 13 14 50 or, if services are based in teaching hospitals, through the appropriate Language Services within the Social Work Department at the respective hospital. In the interest of ensuring client confidentiality, clients should be provided with the option of either a telephone interpreter from interstate or a local on-site interpreter. Clients should also be given the option of being serviced by an on-site interpreter who may speak the same language but who is not from the same ethnic community.

When working with clients from diverse cultural and linguistic backgrounds, consideration must be given to any traumatic pre- and/or post-migration experiences. Refugees living in Australia may have been exposed to torture which could include rape, sexual violence and forced female genital mutilation. As this information may not yet have been disclosed to family,

spouses/partners, sensitivity must be exercised upon a client's disclosure of these unresolved traumatic events.

Additionally, refugees may have past experiences that could impact on their ability to trust government services and which could negatively affect their interaction with current medical staff. Past experiences of trauma have the potential to hinder the relationship with services providing support, if those experiences have not been disclosed or understood by the service provider.

For further information about working with people from culturally and linguistically diverse backgrounds staff can contact the WA Transcultural Mental Health Services on 9224 1760, Association for Services to Torture and Trauma Survivors (ASeTTS) on 9227 2700, ISHAR Multicultural Centre for Women's Health (9345 5335) or MAITRI Mental Health Services (9328 2699) or Multicultural Women's Advocacy Service (9227 8122 or 9328 1200).

Information on multicultural communities may be obtained from the Office of Citizenship and Multicultural Interests on (08) 9217 1600 or www.omi.wa.gov.au. Information about settlement data of new and emerging communities may be obtained from the website of the Department of Immigration and Citizenship www.immi.gov.au

4.3 People with a disability

Disability includes intellectual, physical, sensory, psychiatric or neurological impairment. Some impairments may involve a reduction in the client's capacity to communicate or make informed decisions. As a matter of good practice, inpatient mental health services should consult with specialist agencies or departments such as the Disability Services Commission, which has specific expertise in supporting people with a disability. Mental health services must facilitate access to appropriate support to meet the needs of a client with a disability. Staff can contact the Disability Services Commission on (08) 9426 9200, or country callers (free-call) on 1800 998 214. For clients whose disability impairs their capacity to make decisions, please refer to section 4.6.

4.4 People who are deaf or hearing impaired

Clients who are deaf or hearing impaired face significant issues and barriers

in accessing services. The deaf and hearing-impaired population is diverse and may include clients who are late deafened, deaf-blind and also from non-English speaking backgrounds. A culturally sensitive response should be provided, giving consideration to environment and the need for interpreters. For further information about working with people who are deaf or have a hearing impairment, staff can contact WA Deaf Society on (08) 9441 2677.

4.5 Older people

Older people with a mental illness are particularly vulnerable to abuse and are often less likely to report such abuse for fear of negative consequences, such as abandonment by family. Older people may also have an impaired capacity to make decisions or voice their needs as a consequence of the deleterious cognitive effects of ageing.

If abuse is suspected, mental health services must ensure an appropriate and sensitive response and facilitate access to appropriate support workers and service options. For more information about working with older people staff can visit Seniors Resources Online:

<http://www.communities.wa.gov.au/serviceareas/seniors/Pages/default.aspx>

4.6 Impaired capacity

Capacity is related to a person's ability to make reasoned decisions in their own best interest. Capacity is not determined by whether a client is a 'voluntary' or 'involuntary' patient. Capacity may be impaired as a result of disability, medication, emotional trauma and/or mental illness. The impact of impaired capacity may be problematic in relation to the decision-making process.

For the purposes of these guidelines an incapable person refers to:

- A person who is unable, by reason of a mental disability, to understand the nature, effect, reasons and consequences of the procedure; or
- A person who is unconscious or cannot understand the nature of the request and communicate a response.

Having impaired capacity in relation to one area of life or one aspect of a

situation does not mean that a client does not have the capacity to make decisions regarding other areas or situations in their life.

Staff should determine at each stage if the client:

- Understands the nature and effect of the decision;
- Is able to make decisions freely and voluntarily; and
- Can communicate the decision in some way.

Where concerns exist regarding a client's ability to make informed decisions, an assessment of capacity should be undertaken by the appropriate medical personnel.

The determination of capacity should be confined to the context of making an allegation of sexual assault. An individual suspected of having a decision-making disability should be assessed by an experienced clinician to determine the type and level of assistance required, and the appropriate action to take. Staff should ensure every effort is made to determine whether a Guardian has been appointed to the individual.

It is important to note that the responsibility for making sure that a person understands the nature and consequences of a medical and forensic examination and for obtaining informed consent to treatment rests with the treating psychiatrist or involved medical practitioner.

Staff can contact the OPA to discuss any queries about the sexual assault of an incapable person or to request assistance with progressing an application for a guardianship order.

During business hours staff can contact the OPA Telephone Advisory Service on Free Call 1300 858 455 or access an after hours service via this number.

4.7 Persons aged under 18 years

4.7.1 Mandatory reporting of child sexual abuse

Under the *Children and Community Services Act 2004* the definition of sexual abuse in relation to a child, includes sexual behaviour in circumstances where –

- (a) the child is the subject of bribery, coercion, a threat, exploitation or violence; or
- (b) the child has less power than another person involved in the behaviour; or
- (c) there is a significant disparity in the developmental function or maturity of the child and another person involved in the behaviour.

The mandatory reporting requirements must refer to this definition of child sexual abuse rather than the definition provided in these Guidelines.

The *Children and Community Services Act 2004* requires doctors, nurses, midwives, police and teachers to report when they have a reasonable belief that sexual abuse of a child has occurred or is occurring. The legislation was enacted on 1 January 2009. All doctors, nurses and midwives working for WA Health must complete the mandatory reporting information session. This includes permanent, contract and part-time staff as well as visiting medical practitioners. Other doctors, nurses and midwives must follow the Department for Child Protection guidelines. More information can be found at: <http://mandatoryreporting.dcp.wa.gov.au/Pages/Home.aspx> or by calling 1800 708 704.

4.7.2 Consent for medical examination

It is acknowledged that the issue of sexual assault within adolescent mental health services may be complex and multifaceted. For clients under 18 years of age, conflict may arise in relation to the wishes of the client, the expectations of parents and the obligations on staff when reporting or responding to allegations of sexual assault.

In 1986, the Gillick case in the United Kingdom established the legal precedent that an adolescent under the age of 18 years is capable of giving informed consent when he or she ‘achieves a sufficient understanding and intelligence to enable him or her to understand fully what is proposed’ (the “mature minor” principle). This principle was endorsed in Australia in 1992 by the High Court of Australia (‘Marion’s case’).

Health professionals working with adolescents must, therefore, make a judgement as to whether or not an adolescent is competent to understand

the consequences of their actions and choices.

Clearly, this will vary with the complexity of the situation. Under the *Children and Community Services Act 2004* adolescents who are considered to be mature enough to consent can not be owed the same duty of confidentiality as adults as per the mandatory reporting requirements. It is important that they are informed of this legislation.

The importance of this is highlighted by the fact that adolescents are much more likely to access healthcare if they are given some assurance of confidentiality. Conversely, they are more likely to avoid seeking help for sensitive medical/health problems if some degree of confidentiality is not assured.

For more information about the “mature minor” principle please see the Consent to Treatment Policy for the Western Australian Health System (pages 4,7,8 and 23) :

<http://www.health.wa.gov.au/circularsnew/attachments/404.pdf>

Services are encouraged to develop local service policies and procedures, consistent with existing legislation, to effectively respond to these issues. These policies should include the need for comprehensive documentation about the incident, the client’s expressed wishes including reporting, the process of advising parents and carers and the appropriate actions taken.

4.7.3 Consent for forensic procedures

The “mature minor” principles will apply to a child of any age who possesses sufficient intellectual capacity and emotional maturity to understand the nature and consequences of the procedure to be performed. If the Police are not involved and the child is capable of giving consent, consent to the forensic procedure does not need to be obtained from the parent or legal guardian. If the child is not capable of giving consent, consent only needs to be obtained from the parent or guardian. If the Police are involved, the consent of both the child and the responsible person is required if the child has reached ten years of age and there are no reasonable grounds to suspect that he or she is an incapable person. If the child is under ten or is an incapable person, consent only needs to be obtained from the responsible

person. Consent to a forensic procedure cannot be given by the Department of Child Protection unless the child has been taken into the care of the Chief Executive Officer of that Department, in which case consent can be given by the Chief Executive Officer of that Department.

4.7.4 Child Protection Unit, Princess Margaret Hospital

If the child is under 16 years of age, they should be referred to the Child Protection Unit (CPU) at Princess Margaret Hospital (PMH) for medical/forensic examination and appropriate treatment, including for possible pregnancy or STI.

4.7.5 SARC services for children over 13 years of age

SARC also offers a medical, forensic and counselling service to adolescents aged over 13 years. As there is an overlap in services between PMH and SARC, where children in the 13-16 year age group will be seen will depend on the individual case and maturity of the child.

The following table outlines different scenarios and the way in which consent for both the medical and forensic examinations needs to be given when an allegation of sexual assault has been made.

Table 1: How to obtain consent if different cases.

Patient	No Police Involvement	If Police Are Involved
<p>13-17 yrs inclusive</p>	<p><u>Medical exam</u> - consent as per “mature minor” principles. <u>Forensic exam</u> - the “mature minor” principles also apply and consent cannot be obtained by the Department of Community Protection unless the child is under the care of that Department.</p>	<p>13-17 years <u>Medical exam</u> - consent as per “mature minor” principles. Forensic exam - If a child has reached ten years of age and is thought to be capable the consent of both the child and the “responsible person” is required. The doctor needs to check that the Criminal Investigation Act (CIA) form has been signed, take a photocopy of the form and keep it with the notes. If the child is an incapable person only the consent of the responsible person is required. Note: If a “responsible person” and child have both consented to a forensic procedure being done on the protected person either the “responsible person” or the child can withdraw consent.</p>
<p>Capable adult 18 years and over</p>	<p>Medical and forensic exam - consent for both able to be obtained from the patient.</p>	<p>Medical - able to obtain consent from patient. Forensic - need police to first obtain consent using the CIA form. The doctor needs to check that this form has been signed. Take a photocopy of the form and keep it with the notes. The doctor still needs to obtain consent her/himself. Note - the patient may change his/her mind and withdraw consent at any time before the examination has been completed (section 87 of the CIA).</p>
<p>Incapable person 18 years and over</p>	<p>Medical Exam - use Office of the Public Advocate hierarchy list. Forensic exam - Office of the Public Advocate will need to be contacted and a plenary guardian appointed. If this is not possible then an application can be made to the Supreme Court for an order in respect of the person.</p>	<p>Medical - use of the Public Advocate hierarchy list. Forensic exam - need police to first obtain consent using the CIA form from a “responsible person” e.g. parent or guardian, as listed and detailed in the CIA. The doctor needs to check that this form has been signed. Take a photocopy of the form and keep it with the notes. If the patient does not wish to go ahead with the examination, it is important not to re-traumatise the patient by proceeding, even if the responsible person may withdraw consent at any time before the examination has been completed.</p>

Section 5: Staff and service information

5.1 Staff support and debriefing

Regular exposure to people who have experienced trauma is stressful and can impact negatively on staff. To ensure there is effective support and prevent staff 'burnout', health services should be guided by the following:

- Staff should take time to care for themselves and take opportunities to seek support and assistance if they are feeling 'burnout', 'compassion fatigue' or 'vicarious trauma';
- Staff should be provided with the opportunity to seek independent support, should they choose, to ensure that their involvement in the incident does not contribute to 'compassion fatigue' or other emotional and psychological trauma;
- Senior management should lead in providing mechanisms and opportunities for staff to debrief on both personal and operational issues, as well as in seeking guidance and support from line managers;
- Staff can access the Employee Assistance Programs (EAP) for free and confidential counselling in their area; in addition
- Staff can contact SARC on (08) 9340 1828 (crisis line - 24 hours); 1800 199 888 (rural free call) and (08) 9340 1820.

5.2 Education and information provision for staff

Education and information about issues affecting clients who experience sexual assault and sexual abuse can contribute to increased staff knowledge and understanding. It can also enable staff to understand how they can contribute to providing clients with the best possible response, as well as improving knowledge about existing services that can provide additional support, referral options and assistance to both staff and clients.

Mental health services should create opportunities to:

- Include training and information about sexual assault, sexual abuse and sexual safety as part of induction and orientation programs for all mental health staff;

- Provide training and orientation in relation to sexual assault, sexual abuse and sexual safety at regular intervals in appropriate forums such as staff meetings or in-service training;
- Provide information about and access to existing policies and procedures in relation to sexual assault, sexual abuse and sexual safety;
- Facilitate access to information about sexual assault; sexual abuse and sexual safety by displaying appropriate materials either on a notice board, policy manual or in an area to which staff have access;
- Involve relevant local services in the delivery of training and information sessions about sexual assault, sexual abuse and sexual safety;
- Provide staff with information regarding opportunities for training and professional development and support access to these opportunities; and
- Support and encourage staff to have access to comprehensive and relevant information resources and policies to assist them in providing an effective and appropriate response to issues of sexual assault, sexual abuse and sexual safety.

5.3 Confidentiality, documentation, and record keeping

Health professionals (including public health authorities) are under a common law duty to maintain the confidentiality of all information that comes to them in the course of providing medical treatment and care to patients. They also have a statutory duty to maintain confidentiality under section 206 of the *Mental Health Act 1996*. For more information see the *Patient Confidentiality and Divulging Information to Third Parties* (Department of Health, Operational Circular 2050/06), which relates to confidentiality.

Confidentiality matters are particularly relevant to the circumstances covered in these guidelines. Confidentiality of information and security of records is imperative and central to treating clients with respect and

dignity.

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

- Comprehensive and contemporaneous (written down at the time) documentation and maintenance of accurate records is imperative to ensure an appropriate response, effective management and service accountability;
- Access to and disclosure of personal information regarding the assault will be limited to people directly involved in the case;
- Specific details of the alleged sexual assault should not be made within the medical notes. A separate file should be used for this purpose as per the Western Australian Health Complaint Management Policy (2009).⁸ However, a reference must be made in the clinical file regarding the incidence of the alleged sexual assault with reference to the existence of a separate confidential file.
- A Critical Incident Notification Form should be completed;
- Clients should be advised that, in some instances, there may be a legal duty to produce certain documents, for example, subpoenas, summons, notices of non-party disclosure and warrants. From a clinical perspective and with a view to fostering trust between staff and clients, staff may wish to advise the client when a court document that requires the production of records from their medical file has been received. In addition, if staff consider the release of information about the client could adversely affect the client's health (physical or mental), they should first obtain legal advice (through their district manager) regarding their obligations to produce documents; and
- In most other cases, the consent of the client/guardian must be sought in relation to the release of information (in some circumstances disclosure may also be justified in the public interest).

⁸ Refer to Appendix F.

5.4 Other Mandatory Reporting Requirements

In 2010 the *Health Practitioner Regulation National Law (WA) Act 2010 (WA)* was enacted. Under this Act, the Health Practitioner Regulation National Law is applied as a law of Western Australia. Section 141 of the Health Practitioner National Law provides for notification by health practitioners where the health practitioner forms a reasonable belief that another registered health practitioner has behaved in a way that constitutes notifiable conduct and, as soon as practicable, is to inform the national agency of the second practitioner's notifiable conduct. The term "notifiable conduct" is defined to include engaging in sexual misconduct in connection with the practice of the practitioner's profession.

5.5 Cross agency collaboration and liaison

Working relationships, links and partnerships between the staff of mental health services, and external government and non-government agencies should exist in order to provide a comprehensive, integrated and holistic response to the needs of the client. In developing procedures, staff should be guided by the following:

- Provide clients with information regarding their right to seek and access other independent service, support and advocacy options;
- Assist clients to access these options if necessary;
- Develop links and networks with external organisations;
- Work collaboratively with relevant agencies when responding to allegations of sexual assault, including police and representatives from non-government sexual assault services or other services; and
- Document appropriate referral mechanisms to other relevant agencies.

5.6 Evaluation

Regular service evaluation is critical for facilitating a contemporary, effective and 'best practice' service delivery model. Mental health services

should be guided by the following:

- Regularly monitor and evaluate service delivery and service response against locally developed strategic plans and performance indicators;
- Provide clients with the opportunity to contribute to reviews and evaluations;
- Provide family members with the opportunity to contribute to reviews and evaluations;
- Provide staff with the opportunity to contribute to reviews and evaluations;
- Regularly evaluate and review local interagency links and partnerships to assist in an integrated response;
- Provide opportunities and mechanisms for external services to provide feedback and evaluation of service delivery and collaboration with external services;
- Each incident should be investigated. If clusters emerge, a higher level of investigation and evaluation should occur;
- Managers are to keep track of all incidents; and
- An alleged sexual assault is considered to be a serious incident and must be reported to the Office of the Chief Psychiatrist as soon as possible after the incident.

Section 6: Support for clients, family members, carers, and significant others

6.1 Education and information provision

Education and information provision to clients and other people accessing mental health services, either as a visiting service provider or family member, can increase awareness not only about sexual assault but about acceptable behaviour. This can contribute to improved knowledge about what is expected regarding appropriate behaviour and facilitate a safer environment for clients, carers, staff and others. Information should be provided to clients, carers, and family members and significant others in relation to the following areas:

- Client rights and responsibilities;
- What to do and who to speak to if they have an experience that they are uncomfortable with while in the care of the service, or receiving a service in the community;
- What is expected from clients regarding their own behaviour in relation to the rights, privacy and safety of other clients and staff and other people visiting or accessing the service, or while receiving a service in the community;
- Other services, referral and support options;
- The availability of interpreter services for clients from culturally and linguistically diverse backgrounds;
- Consumer grievance and complaint processes;
- Client rights in relation to complaints or grievances and options to access for support and assistance, including the right to independent advocacy support if a client chooses to make a complaint or grievance;
- Information should be provided as soon as is practicable following admission to the mental health service, or commencement of services within the community; and

- Where appropriate, display information on a notice board or in an area that is accessible to all clients, family members and other relevant people accessing the service.

Carers of the alleged victim and carers of the alleged perpetrator have the right to be informed, with the consent of the individuals involved. In addition, carers have the right to be supported through the process even if they are not informed of the alleged event, and should be provided with this support by mental health service.

Carers rights are acknowledged within the *WA Carers Recognition Act (2004)* and the *Carers' guide to information sharing with mental health clinicians - Communicating for better outcomes (2007)*:

http://www.chiefpsychiatrist.health.wa.gov.au/docs/guides/Carers_Guide_Information_Sharing.pdf

6.2 Follow-up support and referral

Clients who disclose sexual assault and/or sexual abuse should be provided with information regarding available options for ongoing counselling and/or support. Staff should continue to monitor and support the client, carers and any other third parties following a sexual assault and provide all possible assistance to support the client in dealing with the experience of sexual assault.

Where a client has disclosed sexual assault or sexual abuse to another client of the service, appropriate support should also be provided to the client to whom the allegation has been disclosed.

Section 7: Policy implementation, evaluation and review

7.1 Policy Implementation and evaluation

The key purpose of the evaluation of the guidelines is to demonstrate that the guidelines have met the main objectives:

- To be informative and easy to use;
- To support staff in responding appropriately to an allegation of sexual assault disclosed within a mental health service;
- To ensure that there is consistency and efficiency in the response; and
- To ensure better outcomes for clients.

In order to achieve this, the WA Health will conduct a survey three years after dissemination of the guidelines.

The survey will have the following components:

- An assessment of the dissemination of the guidelines;
- An assessment of whether the guidelines have been implemented;
- An assessment of whether or not clinical practice is moving towards the recommendations made in the guidelines; and
- An assessment of whether or not the guidelines have contributed to any changes in clinical practice or health outcomes.

7.2 Policy review

The evaluation of the guidelines will inform the review which will take place after the three year timeframe has passed.

The review will follow the following steps:

1. A multidisciplinary group similar to the *Responding to an Allegation of Sexual Assault Disclosed within Mental Health Services* working group will assess the guidelines to see whether there is any new evidence that should be incorporated.
2. The group will assess how the dissemination and implementation

process has worked and incorporate suggested improvements.

3. The group will draw on current practise and experience as well as on recent data in order to review the guidelines.

Appendix A: Working Groups

Working Group 1

Barbara Ahmat	Statewide Indigenous Mental Health Service
Pip Brennan	Health Consumers Council
Brooke Butler	Mental Health Division
Dr Rowan Davidson	Chief Psychiatrist
Peta Gough	South Metropolitan Mental Health Services
Jodi Henderson	Child and Adolescent Representative, South Metropolitan Mental Health Services
Lee Henry	Child Protection Unit, Child and Adolescent Health Service
Merryn Kenderdine	Consumer Representative
Gillian Lawson	Office of the Public Advocate
Sorrel Mayer	Sexual Assault Resource Centre
Lyn O'Brien	Social Work Representative, South Metropolitan Mental Health Service
Peter O'Hara	Office of the Chief Psychiatrist
Dr Maureen Phillips	Sexual Assault Resource Centre
Dr Jonathan Rampono	Chair Group 1, Responding to an Allegation of Sexual Assault Disclosed with a Public Mental Health Service; Chair of Psychological Medicine, Women's and Children's Clinical Care Unit
Suzanne Scott	Clinical Psychology Representative, South Metropolitan Area Health Services
Tania Towers	Sexual Assault Resource Centre
Dr Alexandra Welborn	Forensic Mental Health Representative, Graylands Hospital
Lyn Willox	Carer Representative

Working Group 2

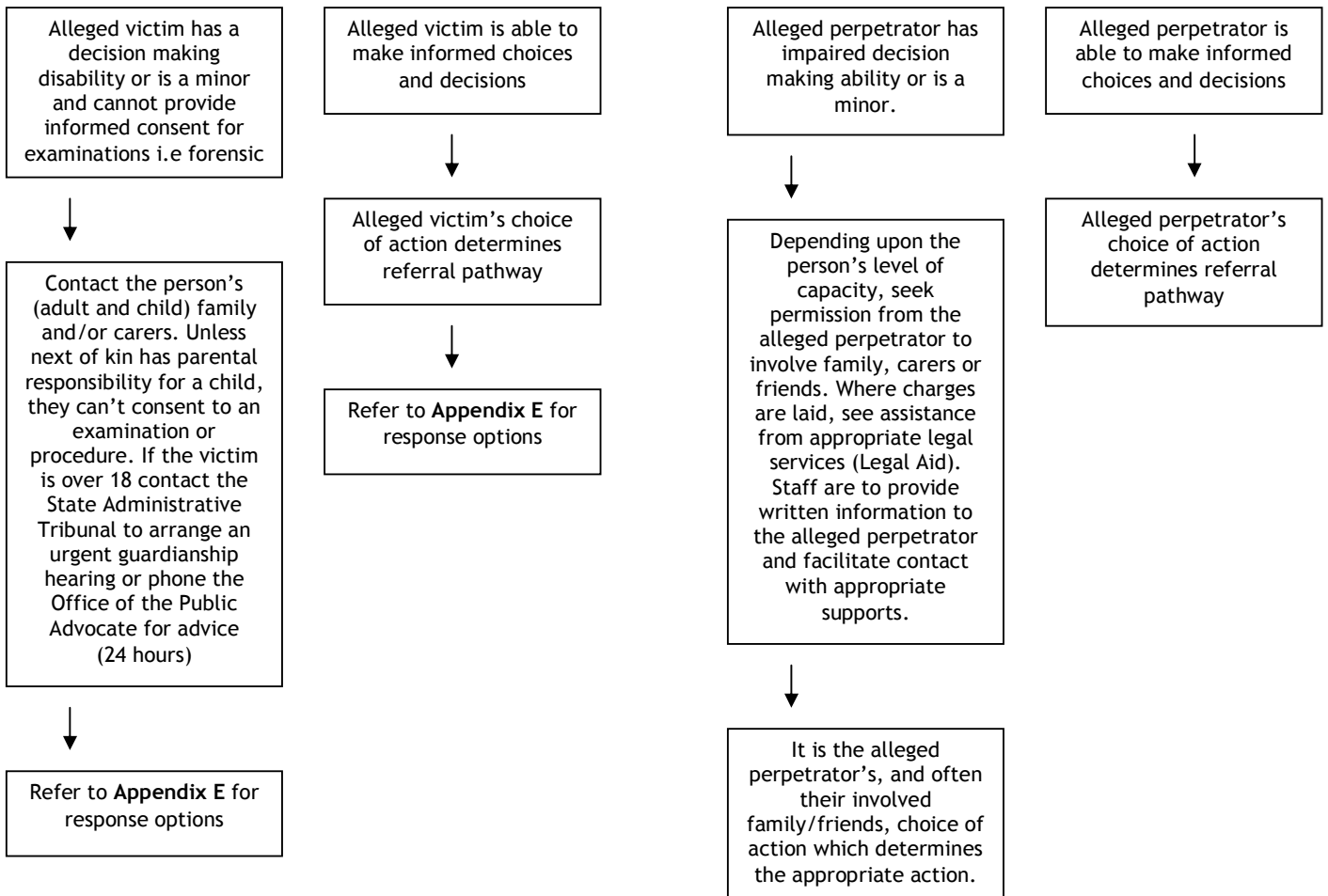
Barbara Ahmat	Statewide Indigenous Mental Health Service
Beth Clifton	Sexual Assault Referral Centre
Pip Brennan	Health Consumers Council
Soo-Ming Chung	Women's Health Services and Clinical Care Unit
Dr Rowan Davidson	Chair Group 2, Working Group Responding to an Allegation of Sexual Assault Disclosed within a Public Mental Health Service; Chief Psychiatrist
Dr Ann Hodge	North Metropolitan Area Health Service
Lee Henry	Child Protection Unit, Child and Adolescent Health Service
Gillian Lawson	Office of the Public Advocate
Fran Lane	Reclaiming Voices
Richard Menasse	WA Country Health Services
Peter O'Hara	Office of the Chief Psychiatrist
Dr Maureen Phillips	Sexual Assault Resource Centre
Tania Towers	Sexual Assault Resource Centre
Dr Alexandra Welborn	Consultant Psychiatrist with mental health expertise

Appendix B: Services of Assistance

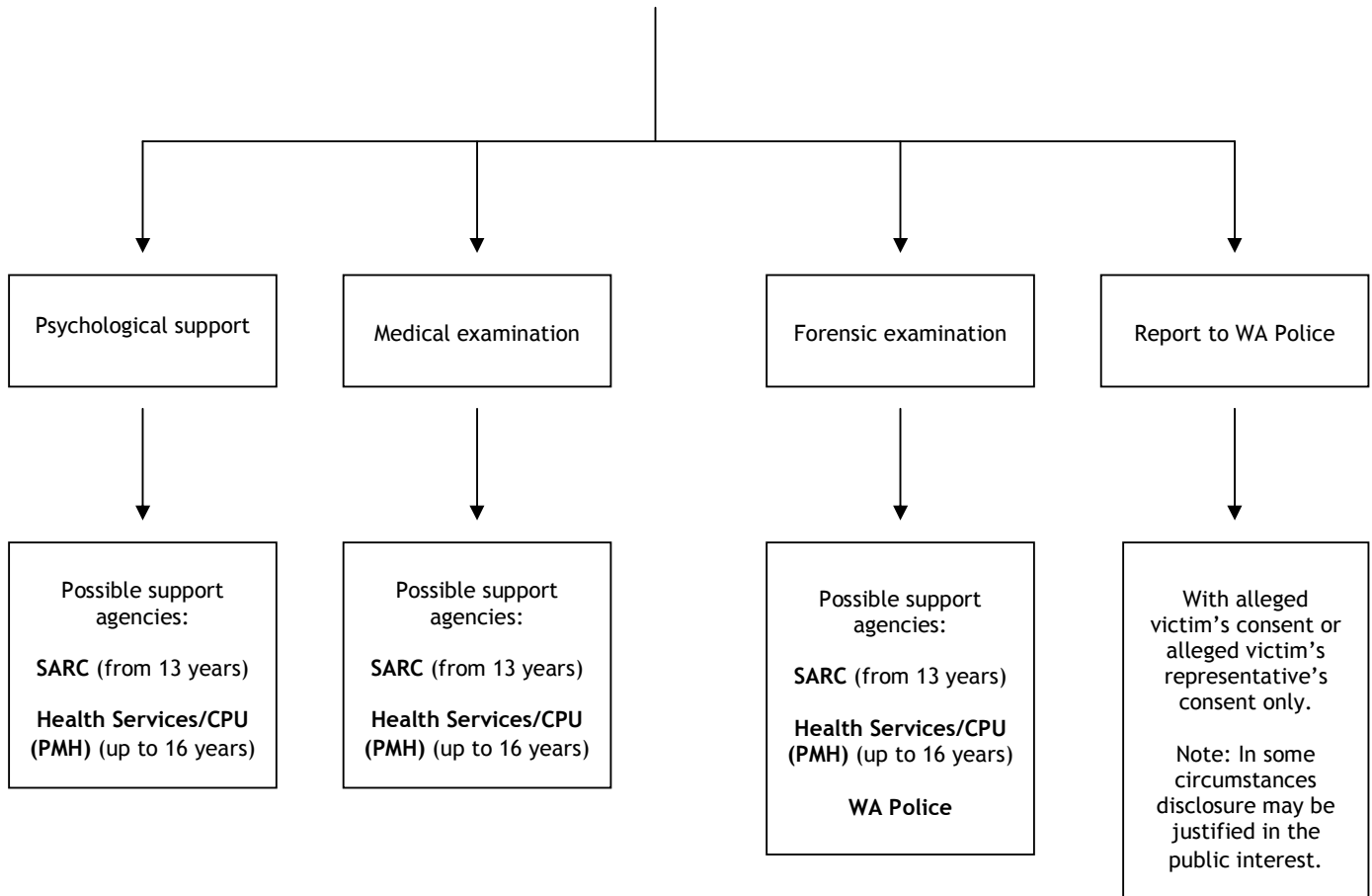
SERVICE NAME	TELEPHONE CONTACT
Alliance for the Prevention of Elder Abuse WA	9479 7566 1800 655 566
ARAFMI - Mental Health Carers and Friends Association	9427-7100 1800 811 747
Carers WA - Carer Advisory and Counselling Service	9228 7400 or 1300 227 377 1800 007 332
Department for Child Protection - Mandatory Reporting Service - Crisis Care	9222 2555 TTY 9325 1232 1800 622 258 9223 1111 1800 199 008
Disability Services Commission WA	9426 9200 1800 998 214 TTY 9426 9315
Domestic Violence Lines - Men's Domestic Violence Help Line - Women's Domestic Violence Helpline - Crisis Care Helpline	9223 1199 1800 000 599 9223 1188 1800 007 339 9223 1111 1800 199 008
Employee Assistance Program (EAP)	http://intranet.health.wa.gov.au/eap/home/access.cfm
Mental Health Law Centre WA	9328 8266
Office of the Chief Psychiatrist	9222 4462
Office of Multicultural Interests	9217 1600
Office of the Public Advocate	9278 7300 or 1300 858 455
Princess Margaret Hospital, Child Protection Unit (CPU)	9340 8646
Reclaiming Voices - Advocacy and Support for Victims of Sexual Assault	9226 4170
SARC - Sexual Assault Resource Centre - 24 HourCrisis Line - Counselling services	9340 1828 1800 199 888 9340 1828
SECCA- Sexuality Education, Counselling and Consultancy Agency	http://gdhr.wa.gov.au/contact/contact-form
Senses Foundation	9473 5400 TTY 9473 5488
SSDAG- Same Sex Domestic Abuse Group	0414585575
Statewide Indigenous Mental Health Services	9347 6866
Transcultural Mental Health Centre	9224 1760
Translator and Interpreting Services (TIS)	13 14 50
WA AIDS Council	9482 0000
WA Deaf Society	9441 2677

Appendix C: Services in Regional Areas

SERVICE NAME	TELEPHONE CONTACT
Acacia Support Centre, South Hedland - Counselling service	9172 5022 (Office 8-4pm) 9172 5044 (24 hour Crisis Line) 1800 746 487
Albany Regional Hospital - Counselling service	9892 2265
Allambee Counselling Service, Mandurah - Counselling service	9535 8263
Chrysalis Support Service, Geraldton - Counselling service	9964 1853 (Office 9-5pm) 9964 1833 (24 hour Crisis Line)
Eastern Goldfields Sexual Assault Resource Centre, Kalgoorlie - Counselling service	9091 1922 (24 hour Crisis Line) 1800 688 922
Karratha Population Health West - Counselling support	9143 2221
Kinway Anglicare Kununurra - Counselling service Broome - Counselling service	9166 5000 9194 2400
Kimberley Interpreting Service (KIS)	91693161
Waratah Women's Support Centre, Bunbury - Counselling service	9791 2884 (24 hour Crisis Line)



Appendix E: Responses to be used with individuals with informed decision making capacity alleging sexual assault within 14 days



In the event that an individual discloses post-14 days, individuals must still receive relevant medical and psychological support and be given the opportunity to report to WA Police, although the likelihood of forensic detection will be diminished.

The response outlined in this flow chart should be considered in conjunction with local policies/procedures and guidelines of the service.

Appendix F: Relevant policies

- **Misconduct and Discipline Policy 2009**
<http://www.health.wa.gov.au/circularsnew/attachments/420.pdf>
- **WA Health Code of Conduct**
<http://intranet.health.wa.gov.au/codeconduct/home/code.cfm>
- **WA Public Sector Code of Ethics**
http://www.opssc.wa.gov.au/Documents/Official_Conduct/Code_of_Ethics_08.pdf
- **Western Australian Health Complaint Management Policy 2009**
<http://www.health.wa.gov.au/circularsnew/attachments/449.pdf>

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