

**ATTACHMENT SF 1**

This is the attachment marked "**SF 1**" referred to in the witness statement of Angelina Sabin Fernbacher dated 21<sup>st</sup> July 2015.

health

Department of Health

# Service guideline on gender sensitivity and safety

Promoting a holistic  
approach to wellbeing

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Promoting a holistic  
approach to wellbeing



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Published by the Mental Health, Drugs and Regions Division, Victorian Government,  
Department of Health, Melbourne, Victoria.

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Printed on sustainable paper by Metro Printing, 203-205 Roberts Road, Airport West.

July 2011 (1105012)

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## Minister's foreword

I am pleased to offer this guideline into Victoria's mental health, and alcohol and other drug (AOD) services in order to improve the safety of people who use these services.

Every Victorian deserves to access treatment services in a safe and secure environment. As a critical part of this, services and practitioners should consider the needs, wishes and experiences of people in relation to their gender and sexual identity to ensure access to high-quality care based on dignity and respect.

These guidelines are a positive step forward to improve the safety of women accessing treatment and care through the development of gender-specific spaces. They are an important part of the Victorian Government's commitment to invest in initiatives that are gender sensitive and responsive to individual needs.

The advice this guideline provides will assist mental health, and alcohol and other drug services in providing a safe environment that takes into account the full spectrum of individual needs which can impact on health and wellbeing.

I look forward to working with practitioners and services across the clinical and community sectors in mental health and AOD to ensure that Victorians are able to access services in a way that is responsive and considerate of emotional, physical and sexual safety.



**Hon Mary Wooldridge MP**  
**Minister for Mental Health**

## Acknowledgements

The Mental Health, Drugs and Regions Division of the Department of Health would like to acknowledge the contributions of those who participated in the development of this guideline. We would like to thank those involved throughout the consultation process. In particular, we would like to thank the following people.

We would like to thank Ms Julie Dempsey for her generosity in sharing her experiences and insights about safety issues for inpatient units.

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# Introduction

## Purpose

Mental health and alcohol and other drug (AOD) services have a responsibility to provide a safe and supportive environment for individuals accessing these services. To this end, services must take all reasonable steps to protect people's physical, sexual and emotional safety whilst effectively responding to their particular needs, experiences and preferences.

This guideline sets out what is required of services and individual practitioners to provide gender-sensitive care for women, men and people who identify as transgender or intersex. The guideline is intended to provide all specialist mental health and AOD service staff and leaders with guidance to support care that is sensitive to gender-related issues, responsive to individual needs and that considers the range of factors that impact on people's wellbeing.

## Definitions

Gender-sensitive practice involves an approach to care that takes gender into account in all interactions with people. Gender-sensitive practice acknowledges the different experiences, expectations, pressures, inequalities and needs of women, men, transgender and intersex people. In addition, gender-sensitive practice takes into account people's gender identity and sexual preferences, along with a range of other factors that interplay with gender to impact on people's wellbeing. Importantly, gender-sensitive practice recognises people's lived experiences and is particularly responsive to experiences of trauma.

## Background

Gender is a key marker of identity and a strong predictive factor connected to health and wellbeing outcomes. The expression and experience of mental health and AOD issues can thus be understood in the context of gender. This 'gendered' understanding relates to risk factors, prevalence, manifestation of symptoms, experiences of symptoms and effects of treatment.

Mental health and AOD services work with a diverse population across a range of different settings. People accessing these services, often in times of crisis, may experience lower levels of resilience and be more vulnerable to victimisation and abuse due to their mental health or AOD issues. This, coupled with evidence that identifies the high incidence of experiences of previous abuse, may make some people more vulnerable to further experiences that compromise their safety and wellbeing. In this context, people's physical, sexual and emotional safety can sometimes be compromised within the treatment environment. In order to ensure people's optimal safety and wellbeing, gender-sensitive care involves a strengths-based, holistic approach that is responsive to individual needs, preferences and experiences.

## Policy context

The Department of Human Services released the *Gender sensitivity and safety in adult acute inpatient units project report: Final report* (the 'gender sensitivity and safety report') in 2008. The report identified a range of issues related to the treatment and care of people in mental health acute inpatient environments, including a need for clearer policy and guidelines to promote more consistent and responsive practice.

The Chief Psychiatrist's guideline *Promoting sexual safety, responding to sexual activity, and managing allegations of sexual assault in adult acute inpatient units* was subsequently released in 2009. The Chief Psychiatrist guideline outlines key legislation and policy in relation to gender sensitivity and sexual safety and establishes minimum standards for responding to sexual activity and allegations of sexual assault in adult acute inpatient settings.

This *Service guideline on gender sensitivity and safety* was similarly initially intended to be a service guideline for inpatient units. However, the scope of the guideline has been expanded to include all Victorian clinical, psychiatric disability rehabilitation support (PDRS) and AOD services in recognition of the importance of ensuring the safety and wellbeing of all people accessing these services.

## Key principles

The following principles are expected to inform the delivery of mental health and AOD services:

- People accessing services have a right to be treated with dignity and respect.
- People have a right to access services that are safe and responsive to their particular needs.
- Effective care is responsive to people's lived experience and the particular needs, preferences, strengths, identity and circumstances of each person.
- Services uphold people's physical, sexual and emotional safety at all times.
- Services consider gender sensitivity and safety in service design, workforce development, local policies and procedures.
- Gender-sensitive care recognises that women and men may experience mental health issues differently.
- High-quality care requires ongoing reflection, supervision and education in relation to gender-specific issues, for individuals to ensure sensitivity and safety.
- Trauma can have complex and enduring effects on people that can interrelate with mental health and AOD issues.
- Effective care considers people in the context of their gender identity and sexual preferences, as well as the range of other factors that interplay with gender and impact on people's health and wellbeing.

## Using this guideline

This guideline is arranged into different themes or topics related to gender sensitivity and safety. These include:

- gender-sensitive care
- trauma-informed care
- family violence
- childhood sexual abuse
- bed-based services
- responding to incidents
- gay, lesbian, bisexual, transgender and intersex people.

Each of these topics is organised into three sections: a key message which outlines the topic, guidance for practitioners intended to inform individual practice and guidance for services intended to guide service managers and leaders in providing a gender-sensitive service.

Although people's health and wellbeing can be linked to a range of other factors such as financial stability, employment and education, the factsheets focus on issues that are considered particularly relevant for providing a gender-sensitive service.

This guideline provides an overview of what services should broadly consider in applying gender -sensitive practice to support people's health and wellbeing. However, local policies and procedures, workforce development and service design should also be approached in ways which take into account the particular service setting, populations serviced and any other relevant local factors. Gender-sensitive practice should be an ongoing and core part of services' business.

# Guideline

## Gender-sensitive care

### Key message

Gender-sensitive care (Department of Health 2003) is informed by knowledge and understanding of differences, inequalities and varying needs of women, men, transgender and intersex individuals and the interrelationship of gender identity and sexual preferences with:

- childhood and adult life experiences such as abuse histories and experiences of discrimination
- day-to-day social, family and economic realities such as poverty, housing situation and primary care of children
- expression and experience of mental health and/or AOD issues
- pathways to services, treatment needs and responses such as help-seeking behaviour and the type of service sought
- cultural and community background
- physical health issues such as risk factors and responses to medication.

The guidance for practitioners and guidance for organisations sections below outline the overarching activities involved in providing a gender-sensitive service. These activities can be applied to all the other topics which follow.



### Guidance for practitioners

In order to ensure their practice is gender sensitive, practitioners should:

- undertake professional development activities to ensure current knowledge of best practice gender sensitive care is incorporated into routine practice
- ensure practice is tailored and responsive to gender differences and individual needs
- adhere to local policies and procedures in relation to gender sensitivity and safety
- reflect on how practice can accommodate people's needs and preferences in relation to their gender identity and sexual preferences in order to support people to feel safe and to optimise their wellbeing
- seek professional supervision that encourages reflective practice in relation to gender sensitivity and safety
- participate in team meetings that consider how to best meet people's individual needs
- consider culturally-appropriate practice in engaging with men and women from specific cultures and interpretation of cultural identity with respect to gender, gender identity and sexual identity
- recognise that people from some cultural backgrounds may be affected by gender-based power relationships
- be aware that housing instability and homelessness has an adverse impact on sexual and physical safety
- understand that men and women are sometimes predisposed to different physical health issues and can be impacted differently by side-effects of some medications
- be aware of own gender and the impact this may have on people you are accountable to provide gender sensitive care to.



## Guidance for organisations

Service managers and leaders are responsible for ensuring their organisations:

- consider gender, gender identity and sexuality in relation to people's identity, experiences, safety, resilience, vulnerability and wellbeing
- create a culture in which gender is considered a key marker of an individual's identity and experiences
- promote sensitivity and responsiveness to issues associated with gender through the development of local policies, procedures and programs that consider gender
- ensure a gender-sensitive approach to bed allocation in bed-based services
- ensure a gender-sensitive approach to allocation of staff based on a process of reflection, approaching decisions about matching of people with staff tentatively rather than making assumptions. A request for a staff member of a particular gender can be an opportunity to explore a person's needs
- review existing policies, procedures and practices using a gender-sensitive lens
- develop and implement local policies, response procedures and guidelines in relation to any sexual activity that occurs within the service setting
- effectively respond to disclosures of sexual abuse, harassment and assault
- demonstrate leadership in workforce development by incorporating best practice gender-sensitive care. This should include training, professional development, supervision and reflective practices at all levels (management, supervisors and workers) and across disciplines
- provide service and site-specific information to people accessing the service (and their families and significant others) by clearly indicating the service's commitment to accommodating people's needs and preferences in relation to gender wherever possible
- involve people accessing the service in planning, delivery and evaluation of services
- develop service engagement strategies and partnerships with specialist organisations (such as sexual assault services) including interagency planning groups and co-location of services
- establish cross-agency working groups to facilitate collaboration across sector boundaries (at management, policy and supervision levels)
- establish specialised staff members to implement gender-sensitive practice and provide training, assist with supervision and attend staff meetings
- consider gender in ongoing planning around service design.

## Trauma-informed care

### Key message

#### Trauma

The impact of traumatic experiences is profound and can vary considerably from person to person. The impact may not vary according to whether a person has experienced a single traumatic event or multiple traumatic experiences over a prolonged period. The effects of trauma can manifest physically in the form of headaches, fatigue, aches and pains; mentally as confusion, dissociation, nightmares, flashbacks or poor concentration; emotionally in the form of depression, anxiety, feeling detached or loss of identity; and behaviourally as sleeping issues, eating problems or misuse of drugs or alcohol. Often people's sense of trust, dignity and meaning are significantly impacted following trauma.

Many refugees arriving in Australia have experienced war, torture and trauma and have lost family members, friends and sometimes even entire communities. This trauma may be compounded by experiences of dispossession, displacement, social isolation and discrimination upon arrival in Australia. There are various factors which may increase the risk of mental health and AOD issues in refugee populations. These include the stress and trauma of forced retreat from the country of origin, disruptive settlement experiences and isolation due to loss of social networks, as well as the challenges of adjusting to a new language and culture. High levels of post-traumatic stress disorder, anxiety and depression in refugee populations worldwide and a reported tendency to self-medicate may make refugees particularly vulnerable to developing mental health and AOD problems.

Trauma can be understood to be gendered, both in terms of the prevalence of particular types of trauma as well as in the effects. For example, the incidence of sexual assault is higher among women than men and family violence is predominantly reported as perpetrated by men against women, particularly intimate partner violence. In addition, as described in more detail below, the effects of childhood sexual abuse tend to manifest differently in men and women.

### Trauma-informed care

Trauma-informed care recognises the high prevalence of experiences of assault and abuse amongst people accessing mental health and AOD services, and in the general population more broadly. Trauma-informed care acknowledges the ongoing impact of trauma on people's health, wellbeing and behaviour, and ensures that the care provided is sensitive to trauma-related issues. In particular, trauma-informed services take care to avoid practices that may exacerbate or retrigger previous experiences of trauma and undertake routine enquiry about people's experience of abuse. Where disclosure of past or current abuse occurs, services facilitate effective and coordinated responses based on individual preferences.

In recognising that previous experience of abuse renders people vulnerable to further abuse, and given the high incidence of trauma amongst people accessing mental health and AOD services, a trauma-informed service takes care to ensure the physical, emotional and sexual safety of people accessing the service. In particular, trauma-informed services are designed, arranged and managed in ways that are responsive to trauma, regardless of challenges and limitations within the service environment.

Trauma-informed services acknowledge people's lived experiences as the bedrock for therapeutic decision-making and promote people's choice and empowerment as vital to successful treatment. A trauma-informed approach is based on the recognition that many behaviours and responses (often seen as symptoms) expressed by people are directly related to traumatic experiences, which can be related to mental health, substance abuse, behavioural and physical health concerns (National Centre for Trauma-Informed Care).





## Guidance for practitioners

Trauma-informed practice involves viewing what may have previously been understood as symptoms, as adaptations to traumatic events aimed at managing the traumatic experience. A strengths approach should be taken to understand the adaptive behaviours of people who have suffered trauma. Adaptive behaviour in people who have suffered trauma may appear as if they are not adjusting, which may in turn be the basis of psychiatric diagnosis. However, in the context of trauma-informed care, it is helpful if adaptive behaviour is viewed as a strength rather than a deficit. In responding to individuals, staff should integrate an understanding of the impact of trauma and coping mechanisms. To work effectively with people, practitioners should also develop and demonstrate an understanding of how trauma can be triggered, what people need when trauma is triggered, and how to increase people's safety in order to manage symptoms of trauma.

Trauma may result from violence experienced within relationships. However, the potential for recovery from trauma can also occur in relationships. Accordingly, victim/survivors are best able to heal in relationships (including therapeutic relationships) that are empowering and focus on supporting strengths and learning. Violence and trauma may shape a person's beliefs, feelings, self-perception and relationships with others. Practitioners should be alert to the potential for re-traumatisation through work practices. Family-sensitive practice needs to take past or current interpersonal violence into account and clarification needs to be sought prior to releasing information or organising family meetings.

Tips for practitioners:

- Seek permission to engage with the person on their terms.
- Find out what they find helpful.
- Accept the person's experience without judging, devaluing or making discrediting statements.
- Listen to and reflect the person's language.
- Communicate and promote respect and dignity in all interactions.
- Seek prior guidance from the person as to how to approach contact with family.
- When working with people from refugee backgrounds, demonstrate good practice principles such as predictability, maximising the person's sense of control and respect for the individual's cultural and spiritual life.
- Aboriginal people have a higher reported prevalence of exposure to violence and trauma, this may have specific meanings for different genders.<sup>1</sup>

<sup>1</sup> The Victorian Aboriginal Community Controlled Health Organisation (VACCHO) is the peak Aboriginal health body and may be contacted for advice on how to deliver sensitive and responsive services to Aboriginal people.



## Guidance for organisations

Services need to ensure that a trauma-informed approach is embedded in day-to-day practice and formalised in policies and procedures. Best practice systems view trauma-informed care as a whole-of-organisation approach. At a minimum, organisations need to promote a culture of awareness of the prevalence and impact of trauma. Another way to approach trauma-informed care is to assume that everyone who accesses the service has potentially experienced trauma and to work within a trauma-informed model. In this way, trauma-informed care does not form an optional add-on service, but forms a core part of the delivery of care (Jennings 2004).

Characteristics of an organisation that provides trauma-informed care include:

- staff who are aware of the relationship between experience of trauma and gender
- a service culture that acknowledges and works with issues of trauma that impact on relationships
- an emphasis on people's strengths
- routine enquiry and support about people's safety and assistance with crisis planning
- a focus on wellbeing and recovery
- knowledge of the impact of torture and trauma on people with refugee backgrounds
- awareness of the roles that violence and victimisation play in the lives of those accessing their services
- service design which aims to minimise the possibilities of victimisation and re-victimisation.

Trauma screening and assessment can be an effective way to obtain holistic information, to offer people the option to address abuse issues within the context of the service being provided and to make connections between abuse and current issues. If screening and/or assessment for trauma is introduced, it needs to be supported by organisational or team-based policies and guidelines and undertaken by trained and skilled professionals who are able to:

- communicate clearly about why questions are asked
- respond to disclosures appropriately and provide follow-up support
- understand the impact of trauma on mental health and wellbeing and the relationship between trauma and AOD issues
- have a clear understanding of the type of work they (or their colleagues) can provide in-house and when to collaborate with or refer a person to specialist services (Moses et al. 2003).

## Family violence

### Key message

Family and interpersonal violence:

- Violence against women (VAW) is the leading contributor to death, disability and illness in Victorian women aged 15-44 (Victorian Health Promotion Foundation).
- Thirty-eight per cent of all Australian women experience personal violence in their lifetime (ABS quoted in Judd et al).
- Prevalence rates for interpersonal abuse (sexual abuse during childhood and/or adulthood, child abuse and family violence) for women with mental health or AOD issues range between 49 and 90 per cent.
- Studies estimate that 40 per cent of men diagnosed with mental illness have experienced childhood sexual abuse.
- Family violence can have many short- and long-term effects.
- Family violence can result in depression, anxiety, post-traumatic stress symptoms or disorder, dissociation, suicidality and problematic AOD use.
- Depression is the most common mental health impact of abuse and it is estimated that 47.6 per cent of women victim/survivors suffer from depression.
- Family violence is a major contributor to women's and children's homelessness which, in turn, has an impact on mental health.
- There is a correlation between the frequency, severity, chronicity and recency of violence and the level of psychopathological distress.
- Re-victimisation rates are high for those who have experienced childhood abuse which can exacerbate the experience of victimisation during adulthood.



### Guidance for practitioners

#### Responding to a victim/survivor

In responding to a victim/survivor's disclosure of violence, practitioners should:

- acknowledge the disclosure
- affirm that the responsibility lies with the person choosing to use violence, not with the victim
- take an active part in enquiring about and responding to the disclosure
- acknowledge the impact of violence
- assist in making the connection between the violence and how the person feels
- clarify the practitioner role and what the practitioner can or cannot do
- ensure appropriate secondary consultation or referral without assuming immediate referral is necessarily required and discuss these options with the person
- respect the person's choices and access good supervision or secondary consultation if this is challenging
- determine if children are exposed to violence (Women's Aid Federation of England 2005).

If children are exposed to, or are victims of family violence, staff should refer to local organisational procedures about accessing Child FIRST or Child Protection. Section 28 of the *Children Youth and Families Act 2005* authorises any individual to make a report to the Department of Human Services if the individual has a significant concern for the wellbeing of a child or if they believe on reasonable grounds that a child is in need of protection.<sup>2</sup> The *Children, Youth and Families Act 2005* also provides that a mandatory reporter<sup>3</sup> who, in the course of practising their profession, forms the belief on reasonable grounds that a child is in need of protection because:

- the child has suffered, or is likely to suffer, significant harm, as a result of physical injury and the child's parents have not protected, or are unlikely to protect, the child from harm of that type; or
- the child has suffered, or is likely to suffer, significant harm as a result of sexual abuse and the child's parents have not protected, or are unlikely to protect, the child from harm of that type, must report to the Department of Human Services the reasons why they have formed this belief as soon as practicable after forming the belief, and after each occasion on which they become aware of any further reasonable grounds for the belief.<sup>4</sup>

### Working with people who use violence against family members

In working with people who use violence against family members, practitioners should:

- apply a framework based on therapeutic engagement including raising someone's awareness of their behaviour, working towards accepting their behaviour and then agreeing on actions to change behaviour
- acknowledge the existence or disclosure of violence against a partner/family member. For example 'This is very difficult to talk about and now that you have raised this we now have an opportunity to address violence against your partner as unacceptable. It will be important for you to establish safe behaviour with your partner.'
- affirm or encourage any responsibility taken (when a person has disclosed the use of violence) and appropriately refer to the clinical treatment team

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2 Children, Youth and Families Act section 183. In this context, a child will be considered to be in need of protection if:

- the child has been abandoned by his or her parents and after reasonable inquiries –
  - (i) the parents cannot be found; and
  - (ii) no other suitable person can be found who is willing and able to care for the child;
- the child's parents are dead or incapacitated and there is no other suitable person willing and able to care for the child;
- the child has suffered, or is likely to suffer, significant harm as a result of physical injury and the child's parents have not protected, or are unlikely to protect, the child from harm of that type;
- the child has suffered, or is likely to suffer, significant harm as a result of sexual abuse and the child's parents have not protected, or are unlikely to protect, the child from harm of that type;
- the child has suffered, or is likely to suffer, emotional or psychological harm of such a kind that the child's emotional or intellectual development is, or is likely to be, significantly damaged and the child's parents have not protected, or are unlikely to protect, the child from harm of that type;
- the child's physical development or health has been, or is likely to be, significantly harmed and the child's parents have not provided, arranged or allowed the provision of, or are unlikely to provide, arrange or allow the provision of, basic care or effective medical, surgical or other remedial care.

3 The term "mandatory reporter" is defined by section 182 of the Children, Youth and Families Act and includes registered medical practitioners and registered nurses.

4 Children, Youth and Families Act section 184

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- ensure that information from the victim/survivor is kept completely confidential and appropriately referred to the clinical treatment team
- discuss the violence with the person using violence only when the victim/survivor is not present
- always see partners separately when discussing family violence
- discuss someone's use of violence by focusing on the abuser's behaviour, not on the victim/survivor's disclosure or behaviour
- use a direct and calm approach in all interactions
- paraphrase and reflect back to the person what they have understood about what they've disclosed, for example by using a statement such as 'Are you aware of your actions and the impact it has on your partner/family'
- be respectful of the disclosure and do not reinforce a person's justification for the violence
- consider the safety of the partner and children as the priority
- identify the person's responsibility for how they handle their feelings, for example although mental illness may make the person feel irritable, they are accountable for how they express those feelings towards their partner
- be informed about referral options for help-lines, counselling and behaviour change programs (Greater London Domestic Violence Project, 2007; Ministry of Health – Manatu Hauora, 2002) and (Victorian Community Council Against Violence, 2004).

#### Working with partners involved in intimate partner violence

In situations where both partners involved in intimate partner violence are accessing the same service, it is suggested that practitioners:

- ensure protocols are in place to deal with confidentiality, disclosure and access to files and use these to guide practice
- recognise that it is not a conflict of interest to ask someone if they are exposed to violence
- ensure management of the situation by discussing their own support needs with a supervisor or manager
- not discuss the disclosure with the partner, unless the victim/survivor wishes for this to occur
- recognise that at times of disclosure to others including professionals, victim/survivors are under greater danger of abuse/assault
- address the needs of victim and perpetrator separately
- if abuse is suspected but has not been disclosed, ensure the opportunity for the suspected victim/survivor to speak about it privately
- not offer 'couple counselling' (Victorian Community Council Against Violence, 2004).



## Guidance for organisations

Sensitivity to people's safety, needs and wishes is paramount when working with victim/survivors of family violence and service providers need to provide care that balances the need to include family with the need to protect the individual. However this does not mean that if abuse is present, the family will automatically be excluded. It is likely that what will be necessary might include one or more of the following:

- a team approach to problem-solving tailored to the individual
- close monitoring and regularly reassessing of the situation
- appropriate use of manager and peer supervision (Women's Aid Federation of England, 2005) and (Victorian Community Council Against Violence, 2004).

Ultimately, all response processes should support the person to make decisions in collaboration with staff to ensure their wishes for the involvement of family while their safety is upheld.

There are a number of principles and mechanisms through which organisations can develop responsiveness to victim/survivors of family violence.

### Collaboration

At a minimum, working relationships need to be established with local family violence and sexual assault services in order to access secondary consultation, identify referral pathways and facilitate professional development and training of staff.

### Leadership

Senior managers and team leaders need to provide leadership in the area of service responses to family violence. Appropriate supervision for work related to family violence should also be provided to staff across a range of professions. Similarly, internal and external training should be provided as part of the organisation's approach to professional development. Service managers and leaders should also be strategic in promoting the integration of training into routine practice.

### Policy

Services should ensure policies addressing family violence issues, including a clear definition of family violence and an organisational statement on responding to family violence, are provided to new staff and used to inform training within their organisations.

### Visibility

Posters and information about family violence could be displayed in waiting areas and consultation rooms to acknowledge the prevalence and impact of family violence, to point to an organisational willingness to talk about family violence and to indicate the availability of support options offered to people.

## Childhood sexual abuse

### Key message

Childhood sexual abuse has complex and enduring effects on people, which can manifest differently depending on gender and circumstances. Childhood trauma is known to manifest differently in men and women and is understood to impact on growth and development.

In women, a history of a range of childhood traumas including sexual abuse is correlated with:

- poorer physical and mental health and a lower health-related quality of life than women without such experiences
- health problems, including chronic pelvic pain, gastrointestinal disorders, intractable low back pain, chronic headache and ischemic heart disease
- adaptive coping strategies which can contribute to poorer health outcomes (for example use of alcohol or drugs and unsafe sex)
- problematic drug and alcohol use, substance use disorder and self-harm
- higher rates of childhood mental disorders
- higher likelihood of developing depression, anxiety, suicidal ideation and post-traumatic stress disorder
- diagnosis of borderline personality disorder (Arias, 2004; Banyard, Williams & Siegel, 2004; Bloom, 2000; Gerlock, 1999; Mullen et al 1988; Spataro et al 2004).

In men, a history of childhood sexual abuse is correlated with:

- anxiety, low self-esteem, guilt and shame, depression, post-traumatic stress disorder (or symptoms), withdrawal and isolation, flashbacks, dissociative states or dissociative identity disorder, emotional numbing, anger and aggressiveness, hyper-vigilance, passivity and an anxious need to please others
- adult onset of mood, anxiety and substance use disorders
- substance abuse, self-injury, suicide, depression, rage, relationship difficulties, problems with self-concept and identity and discomfort with sex
- increased risk of HIV
- anxiety and confusion about sexual identity and sexual orientation
- increased risk of 'acting out aggressively'
- contact with the criminal justice system (Ibid).



### Guidance for practitioners

Upon disclosure of past sexual abuse, practitioners should:

- accept and validate the information without judgement
- express empathy and care
- clarify confidentiality
- if appropriate, express that the person is not alone in their experience (you can acknowledge the prevalence of abuse, in doing so be careful not to minimise the individual's experience)
- clarify time limitations (dependent on the setting, for example if limited time is available to discuss/respond, then clearly state this and ensure follow-up)
- offer reassurance to counter feelings of vulnerability
- work collaboratively with the person to develop a plan for self-care
- recognise that immediate action beyond listening to and supporting the person is not necessarily required
- clarify if this was a first disclosure
- recognise that people may be further traumatised by new environments and other people's behaviour and respond in ways that eliminate or minimise this experience for people
- consider speaking to the local centre against sexual assault for secondary consultation or referral to counselling as appropriate (Schachter et al 2008).

Furthermore, in sensitively responding to a disclosure of sexual abuse, (Ibid) practitioners might:

- acknowledge this can be a very difficult and frightening experience
- acknowledge the person's courage in making the disclosure
- acknowledge the trust invested in the practitioner not to disclose this personal information, however duty of care and mandatory reporting requirements may apply and the person should be advised of this
- convey understanding about the impact of the abuse while sustaining hope for the person
- acknowledge the person's current situation and how the abuse seems to have impacted on them; assist the person to make the connection between the sexual abuse and its impact
- acknowledge the person's strengths
- use active listening to provide the person with the opportunity to discuss previous abuse experiences in a supportive environment
- keep one's own reactions in check
- believe the person (where the person has experienced delusions, do not assume that this is one of them)
- confirm that the person is not alone in their experience, while honouring their individual experience and situation
- convey empathy (be clear about the limits of what you can do and communicate that you can seek information and connect the person with a specialist sexual assault service).



If a practitioner feels that they inadvertently responded to the disclosure in an inappropriate way, or if the non-verbal feedback suggests a negative reaction to their initial response, they should clarify the intended message and check with the person for further reaction as soon as possible.



### Guidance for organisations

Organisations need to develop clear local policies and guidelines that advise and support staff to sensitively enquire about people's experiences of previous and current sexual abuse. Services should also provide access to training for staff on appropriate enquiry in relation to abuse. Additionally, on each team there should be a trained senior staff member responsible for and able to provide professional development and supervision to more junior staff around responding to disclosures of sexual abuse.

## Bed-based services

### Key message

In mixed-sex, bed-based environments which service people from a range of backgrounds, stages of illness and degrees of resilience and vulnerability, people may sometimes be exposed to situations they find distressing. In particular:

- sexual, physical and emotional abuse can occur between people residing, visiting or working in such settings
- abuse is not always reported to staff and when reported people have advised it is not always responded to appropriately
- witnessing an incident or dynamic of abuse between people can have a distressing effect on others, especially those with prior history of trauma
- behaviours that appear less harmful than outright violence, such as sexual, physical or verbal harassment, following a person around or making vague sexual advances, can be distressing, re-traumatising and harmful to a person (the extent of distress is person-specific and should not be judged)
- principles of trauma-informed care can assist in promoting and increasing safety in bed-based services (Department of Health 2009).



### Guidance for practitioners

Practitioners should be mindful that people may enter into relationships while in treatment. If behaviour indicates growing attachment to another ensure you engage in an appropriate conversation to support the individual to look after themselves in treatment.

In responding to incidents of inappropriate sexual activity (including sexual harassment) practitioners should:

- request that the sexual activity stops
- assist the person disclosing harassment (if sexual harassment has been reported) by providing counselling, support and debriefing and ensure that the person who has harassed the other person receives clear messages about such behaviour being unacceptable
- intervene without delay and create the opportunity for discussion separately with the people concerned (it is advisable to engage the support of a colleague to ensure the person can be spoken to separately)
- sensitively counsel those involved about the inappropriateness of sexual activity within the service setting (a policy or a 'safety statement' can be helpful)
- consider the need to put behavioural strategies or interventions in place to ensure the safety of all parties
- re-state reasons for the 'no sexual activity' policy in settings where such a policy exists and discuss strategies to reduce reoccurrence
- discuss the incident with the team and ensure strategies are clear for all staff

- clearly document the incident in the records of both people
- follow through with reporting procedures for such incidents
- monitor all parties' level of risk and safety following the incident.

Following an incident of sexual activity or assault in a service, practitioners should attend to people's sexual health needs. This involves ensuring that sexual health checks are undertaken and general health procedures are followed (such as infectious disease checks) where the person consents to this. Practitioners should also ensure the 'morning after pill' and a pregnancy test is offered.



### Guidance for organisations<sup>5</sup>

A suitable response to sexual activity (including sexual harassment) in a bed-based setting involves organisations having policies in place that provide clear directions about the appropriateness of sexual activity within bed-based services and the need to ensure safety and choice of people within those services. Services providing acute and sub-acute care should also ensure that policies and procedures are in place, which communicate the inappropriateness of sexual activity during a person's stay, due to the incompatibility with a therapeutic environment providing mental health or AOD care. Services providing other types of residential care in which it may not be appropriate to prevent individuals from forming sexual relationships (such as residential withdrawal services or continuing care units) should develop procedures and communication strategies which inform staff of their responsibility of ensuring those within the service who do engage in sexual relationships are not being coerced. Organisations should also provide clear guidance on what a 'sexually safe' environment means in practice.

Furthermore, in creating a gender-sensitive environment, services should consider an individual's physical health and ensure that:

- female staff enquire about health needs for women and facilitate health checks and doctor appointments
- sanitary items are made available as part of routine practice; this means that such supplies are stocked and made available to women; it also means that women should not have to ask for these but that staff ensure that they are routinely provided
- health checks and health needs for men are addressed by staff through routine inquiry and staff facilitate health checks and doctor appointments for medical assessments and treatment
- staff understand that people may experience a physical health exam as intrusive.

<sup>5</sup> At times people may decide to enter into intimate relationships that service sectors consider are not in the person's best interests. It is important to understand that people will make choices and establish relationships. The ongoing relationship should be supportive regardless of their choices.

## Responding to incidents

### Key message

As discussed earlier, sexual harassment, assault, physical threats and abuse can occur within any service environment. People accessing services have at times reported witnessing incidents of threatening behaviour and assaults within services, which are generally known to be under-reported. Where such incidents are reported, staff require the necessary skills to respond appropriately in these situations.

Services can promote sexual safety by developing and implementing policies and procedures that:

- support the right to physical, sexual and emotional safety
- encourage and facilitate monitoring of professional boundaries
- require staff to participate in professional development and supervision
- respond appropriately to breaches of safety (New South Wales Health 2004).

Assessment and identification of people at risk of sexually inappropriate behaviours (for example those with a previous sex offending behaviour, sexual disinhibition or aggression) is essential to the promotion of sexual safety within the service. Assessment processes should also identify people who may be vulnerable to sexual assault, for example due to a history of abuse or their current mental health or AOD issues. Identification of risk should be made at initial assessment or contact and regularly reviewed throughout the period of service. A clear plan outlining how any interventions mitigate risk factors must be articulated as part of that person's care plan.



### Guidance for practitioners

In creating a safe service environment, practitioners should:

- understand that witnessing events that are traumatic can have a greater impact on those with a previous history of abuse
- provide debriefing to those who have witnessed a traumatic event and provide some support with managing emotions and distress (a knowledge of someone's history in relation to abuse can assist in sensitive enquiry)
- enquire about what the person is experiencing and what they need, rather than making assumptions about what they may need
- enquire about what it is that people have experienced as traumatic, rather than making assumptions about this
- ensure individual treatment plans address vulnerability to sexually inappropriate behaviour
- understand that at different times people may present as more vulnerable than others and will require active support.



### Guidance for organisations

- Develop local policies to minimise incidents within the service (particularly bed-based settings) and to address them when they occur.
- Offer debriefing as standard response to people following a traumatic event; ensure staff are skilled at debriefing and addressing people's concerns and needs.
- Offer debriefing to staff and visitors who may be affected by an event.
- Provide guidance for respectful engagement with people following a disclosure of previous or recent abuse as well as disclosure of having experienced a traumatic event within the current setting.
- Local policies should include guidance on ensuring people's safety in non-residential settings, including safety from interpersonal abuse (such as from a current or former partner) and appropriate ways to respond.
- Integrate reflective practice principles into meeting structures (such as gender-sensitive reviews and case discussions) to address safety and traumatic events and opportunities for improving future responses.

## Gay, lesbian, bisexual, transgender and intersex people

### Key message

In implementing gender-sensitive practice, services should consider the needs of individuals who do not identify as either female or male, or who do not identify as heterosexual. Gay, lesbian, bisexual, transgender<sup>6</sup> and intersex<sup>7</sup> people (GLBTI) are as diverse as the rest of the community and make up 10 to 15 per cent of the overall population. Those identifying as GLBTI may share some experiences, such as the experience of exclusion and discrimination, but are likely to have a range of different needs depending on the individual. For example, someone questioning their gender identity is likely to have different needs to someone questioning their sexuality. GLBTI people are generally exposed to greater rates of marginalisation and discrimination. Same-sex attracted young people and young people questioning their sexuality may be particularly vulnerable to discrimination and homophobic abuse.

Service responses should demonstrate sensitivity, thoughtfulness and responsiveness about the particular support needs that GLBTI individuals may have. Part of ensuring the gender sensitivity of the service for GLBTI people involves communicating openness and acceptance of people's gender, sexual identity and lifestyle. Any type of homophobic or transphobic discrimination can have a detrimental impact on a person's mental health and wellbeing (Beyond Blue 2009).



### Guidance for practitioners

In working with GLBTI people practitioners need to:

- recognise the diverse needs of GLBTI people
- understand the issues people of diverse gender identity and sexual preference face and be responsive to individual needs
- provide an accessible service and referral to appropriate services/support where necessary
- be sensitive and receptive in talking about and responding to GLBTI people as people share personal information in a range of different ways
- convey openness and a non-judgemental attitude about GLBTI issues
- address transgender people by their preferred gender
- ensure sensitive enquiry occurs about the preferred contact person/partner and make adjustments on intake/assessment forms as appropriate (Ministerial Advisory Committee on GLBTI Health and Wellbeing 2009).

Below are some possible questions that practitioners might use in ascertaining people's needs in relation to their gender identity and sexuality. Questions should be asked sensitively and not sequentially. It can be helpful to introduce questions regarding sexual orientation by explaining why you are asking these questions, for example:

- To determine the best service for each person's needs, I ask all people entering the service about their living arrangements

<sup>6</sup> Transgender people do not identify with the gender of their upbringing.

<sup>7</sup> Intersex people are people who are born with reproductive organs or sex chromosomes that are not exclusively male or female.

- As part of our assessment processes we need to understand how you like to live your life. Can you tell me about your home life, who you live with, who your support people are...?

Other demographic questions about partners and living arrangements might include:

- Do you have a partner? (rather than 'Are you married?')
- What is your partner's name?
- Is your partner female or male? (if the answer to the previous question is unclear)
- Do you live with anyone?
- Who do you regard as your close family?
- Do you have any children?<sup>8</sup>
- Are you co-parenting children with anyone?

The following questions can be useful if the person does not have a partner, in order to understand preferred social networks or to explore health issues related to discrimination:

- How would you describe your sexual orientation (or gender identity)?
- Have you had any negative experiences relating to your sexual orientation/gender identity/intersex status?

Staff should clarify that answering the following questions is optional:

- Gender: female, male, male-to-female transgender, female-to-male transgender, intersex
- Sexual orientation: heterosexual, lesbian, gay, bisexual, same-sex attracted, other (please specify)

This information may be particularly relevant for certain settings such as inpatient units and residential settings where it may be appropriate to offer same-sex accommodation based on the person's wishes.<sup>9</sup>

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8 Also refer to guidance provided by the FaPMI strategy (Victorian Government Department of Human Services, 2007)

9 Ibid

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### Guidance for organisations

To promote sensitive practice when working with GLBTI people, organisations should:

- create an organisational culture that promotes respect and understanding about the needs of GLBTI people
- demonstrate understanding about people's unique experiences in relation to their gender and sexual identity and recognise some of the potential challenges GLBTI people might face
- ensure staff are aware of and skilled in providing care that does not allow discriminatory practice by ignoring the specific needs of GLBTI clients
- provide guidance to address potential risks at the time of disclosure and at transition points (such as discharge from service)
- acknowledge that previous experiences of discrimination may make it more difficult for someone to disclose their sexual preference
- communicate acceptance, reassurance and support to the person at disclosure of their sexual preference
- promote reflective practice by developing and disseminating organisational guidelines stating that staff are expected to question their own assumptions, judgements or prejudice about gender identity and sexual preferences and their potential for homophobia or transphobia
- provide opportunities for staff to increase their knowledge about GLBTI people
- ensure the physical environment reflects an openness to diversity (such as through posters and information leaflets) and is arranged to facilitate easy navigation for GLBTI people (such as unisex toilets).

While intake and assessment forms may not have the capacity to reflect gender and sexual diversity, organisations are encouraged to find ways to incorporate inclusive language in all documentation, including intake data collection. For example 'preferred contact for emergencies' is more inclusive than 'next-of-kin'. Organisational and practice guidelines need to instruct staff to state why questions are asked and how the information will be used. Such enquiry needs to be informed by gender-sensitive practice principles and the information should be treated respectfully.



## Other considerations

Mental health and AOD services aim to optimise the health and wellbeing of people accessing these services. While the core focus of these services will be on people's mental health or substance issues; to deliver effective care, services must also consider a range of other factors that impact on people's health and wellbeing. These include financial and housing situation, family and social relationships, educational and vocational opportunities and physical health. When they are optimal, these are important stabilising and protective factors that support people's health and wellbeing. However, when these factors are problematic, they can adversely impact on health and wellbeing, increase people's vulnerability to mental ill-health and substance issues and expose people to potentially traumatic experiences. People who require support from mental health and AOD services sometimes also face challenges in these other areas. These commonly include unstable housing, physical health issues, difficult or abusive relationships and/or unemployment. In order to ensure the effective delivery of care, services need to consider people in the context of their lives and circumstances through a holistic approach. Services should also consider how these other factors can interplay with gender to impact on people's health and wellbeing.

## Resources

The Asylum Seekers Resource Centre

<http://www.asrc.org.au>

Chief Psychiatrist's guideline for *Promoting sexual safety, responding to sexual activity, and managing allegations of sexual assault in adult acute inpatient units*

<http://www.health.vic.gov.au/mentalhealth/cpg/sexual-safety.pdf>

Families where a parent has a mental illness: A service development strategy

<http://www.health.vic.gov.au/mentalhealth/families/index.htm>

Gender sensitivity and safety in adult acute inpatient units project report 2008

<http://www.health.vic.gov.au/mentalhealth/gender-sensitivity>

The Victorian Aboriginal Community Controlled Health Organisation

<http://www.vaccho.org.au>

Victorian Centres Against Sexual Assault

<http://www.casa.org.au>

Victorian Foundation for the Survivors of Torture

<http://www.foundationhouse.org.au>

The Victorian Transcultural Psychiatry Unit

<http://www.vtput.org.au>

Well Proud - A guide to GLBTI inclusive practice for health and human services

<http://www.glhv.org.au/node/589>

Writing themselves In 3: the third national study on the sexual health and wellbeing of same sex attracted and gender questioning young people

<http://www.latrobe.edu.au/arcshs/downloads/arcshs-research-publications/WTi3.pdf>

Further resources including fact sheets, the literature review, policy examples and case studies will be made available on [www.health.vic.gov.au/mentalhealth](http://www.health.vic.gov.au/mentalhealth) (look under G in the A to Z).

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