

Ahpra & National Boards Targeted Consultation: Draft Guidance – Sexual Misconduct and the National Law

Laurel House Submission

September 2025



Laurel House
SEXUAL ASSAULT SUPPORT
COUNSELLING • EDUCATION • ADVOCACY • CHANGE



Acknowledgement of Country

Laurel House acknowledges and pay respect to the Palawa, who are the Traditional Custodians of the land and waters of lutruwita. We pay respects to Elders past and present. We particularly acknowledge the resistance and resilience of those Aboriginal people who have experienced sexual violence.

Acknowledgement to Victim-Survivors

Laurel House also honour and acknowledge the victim-survivors of child sexual abuse and other forms of sexual violence. We recognise the immense strength it takes to confront and heal from these traumatic experiences. We commit to amplifying your voices, advocating for change, and standing side by side on the path to healing and recovery.

Disclaimer:

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This document was written by Dr. Lucy Mercer-Mapstone (Policy, Advocacy, and Lived Experience Lead) and Elise Whitmore (Policy Officer) with input from Laurel House staff.

About Laurel House

Laurel House is a not-for-profit, community-based sexual assault support service based in North and North-West Tasmania. Laurel House provides a range of trauma-informed, evidence based, therapeutic services to victim-survivors of sexual assault and child sexual abuse, their families and supporters. We also develop and deliver a broad range of programs to adults, young people and children including the provision of therapeutic face-to-face counselling at our centres located at Launceston, Devonport and Burnie and through outreach locations across the North and North-West Tasmania, and 24/7 telephone support and assistance with accessing police and forensic medical processes.

Laurel House partners with the Tasmanian Government in the delivery of the Arch Centres (multidisciplinary centres for victim-survivors of sexual harm). We also deliver services to children and young people (aged 17 years and under) who have displayed harmful sexual behaviours in North and North-West Tasmania.

Our team provides community education and other capacity building programs focused on the prevention of sexual harm and on supporting parents, carers and service providers to better respond to disclosures of sexual violence.

Laurel House plays a key role in policy and advocacy work to improve the lives and safety of victim-survivors and the Tasmanian community. This includes our Lived Experience Engagement Program which provides victim-survivors from diverse backgrounds with opportunities to advocate and drive change.

Contact:

Kathryn Fordyce

Chief Executive Officer

Ph: 0427 739 397

Email: kathryn.fordyce@laurelhouse.org.au

Web: www.laurelhouse.org.au

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Introduction

We welcome the opportunity to contribute to Ahpra and the National Boards' consultation on the draft *Guidance – Sexual Misconduct and the National Law* ("the draft Guidance"). We commend Ahpra and the National Boards for recognising the seriousness of this issue and for taking proactive steps to strengthen protections for the public.

We strongly support the inclusion of a broad and nuanced understanding of sexual misconduct and are encouraged to see this work happening. We have provided suggestions on the general content of the guidance in alignment with the provided questions. Our primary focus in this submission, based on our expertise as a frontline specialist sexual assault service who support a widely diverse range of victim-survivors of sexual harm, is that the guidance as drafted, fails to address intersectionality in any meaningful way.

Intersectionality refers to the way in which different aspects of a person's identity – including but not limited to sex and gender, sexual orientation, race, disability, age, and cultural background as well as aspects of their lived experiences which are likely to attract stigma or discrimination including but not limited to drug and alcohol use, homelessness, sex work, socioeconomic status, migration, and class – interact to shape their experiences of power, privilege, and marginalisation. In the context of sexual misconduct, an intersectional approach recognises that individuals face heightened and unique risks of harm due to either individual or overlapping forms of marginalisation. This is particularly critical in healthcare settings, where inherent power imbalances already exist between practitioners and patients/clients within the professional relationship and will be exacerbated where additional forms of power and privilege become cumulative within that relationship (for example, a white, straight, non-disabled male doctor treating a young gay Indian woman from a migrant background and with English as an additional language).

People from marginalised groups, and those whose lived experience is likely to attract stigma, may be less likely to report misconduct, less likely to be believed when they do, or may not recognise inappropriate behaviour

due to cultural, social, linguistic, or structural barriers as is the case in numerous other related and documented spaces such as sexual violence.

Ahpra's guiding principle is the protection of the public and maintaining public confidence in registered health practitioners. While we believe this draft guidance supports that principle to some extent, it does not go far enough. We understand the intent is to keep the guidance brief and broad, but we are concerned that prioritising simplicity and brevity over comprehensiveness and detail is a missed opportunity. Instead, the guidance should be enhanced to assist health practitioners and the public to the greatest extent possible in understanding the complex, intersecting, and nuanced harms caused by sexual violence, abuse, and misconduct – especially in relationships where they hold significant and often multiple forms of power over their patients/clients. Regardless of the length of this guidance, practitioners have a deep level duty of care to do their due diligence in this space.

There are strong aspects of the draft Guidance we support, including the decision to clarify that “intent” is not a necessary component in identifying sexual misconduct, as is the case with sexual harassment offences (see definition below). Perpetrating behaviour that is minimised as “just a joke” or “not that bad” can have a profoundly harmful impact on victim-survivors, and such minimisation can itself be a form of gaslighting – this is something the Guidance should specifically address. Moving away from such rhetoric is critical in shifting the narratives which have for so long let sexual misconduct be ignored and normalised. Sexual misconduct is frequently nuanced and deceptive, and requiring the establishment of intent risks undermining the lived experience of those affected; this is especially the case in relation to grooming.

It is essential to acknowledge the unique power imbalance inherent in the relationship between registered health practitioners and their patients or clients, especially vulnerable individuals such as children or those from marginalised and/or intersectional identities. While we are encouraged to see power referred to in the draft Guidance, we suggest that more could be said to explain where that power comes from, how it intersects with

privilege, and what impact that has for patients/clients. As Professor Emerita Marilyn Walton stated in ABC's *Four Corners* episode *Do No Harm*:¹

"The doctor-patient relationship depends on trust. So, who else do we go to where we will undress when we're asked to, allow them to touch us in intimate places when they want to, ask us questions about the most intimate things in our lives and we give them answer about those intimate spaces. So that trust is fundamental to our well-being."

Unlike most consumer services, health care is not optional. At some point in our lives, every person will require medical or health care, often in times of vulnerability and those who are vulnerable will often require more access to medical and health care. We must be able to trust registered health practitioners with our bodies, our minds, and our most personal information. The inherent vulnerability that exists in these relationships can be exacerbated or exploited where marginalised and/or intersectional identities are not recognised, understood, or respected. This requires a deeper level of self-awareness by practitioners than is currently encouraged or required by the draft Guidance. It is through this lens that we offer the majority of our feedback below, in addition to general feedback, as we believe such initiatives and guidelines which examine sexual misconduct in the context of inequitably power relationships cannot ethically do so in the absence of intersectional considerations.

Feedback on the draft Guidance

Is the content of the draft guidance clear? Is the language as plain and simple as it could be? Could the content of the guidance be improved?

The draft Guidance is relatively clear. However, in seeking feedback on whether it can be understood by a diverse range of people, we

¹ Baker, E. (2023, February 6). *Do no harm: The doctors who break their sacred oath but are still allowed to practise*. ABC News. <https://www.abc.net.au/news/2023-02-06/do-no-harm-the-doctors-who-break-their-sacred/101937414>

recommend specific cohorts are consulted. For example, these should include (but are not limited to):

- Culturally and linguistically diverse people, specifically those whose primary language is not English (will the guide be available in additional languages, for example?)
- Aboriginal and Torres Strait Islander people, especially those working within Aboriginal and Torres Strait Islander health and medical centres
- Those with lived experience of sexual harm from a registered health practitioner
- A cross-section of registered health practitioners, including those from diverse backgrounds
- People with disability

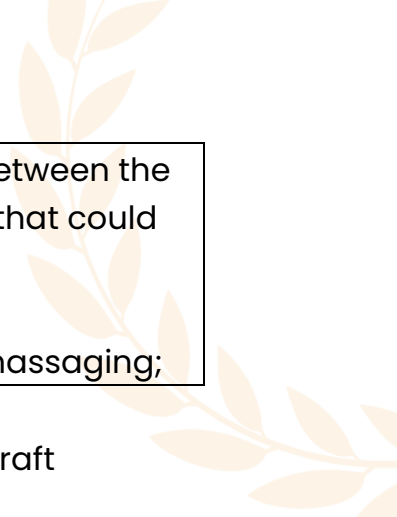
We also recommend that repetitive terms be avoided. For example, *“conduct by a **practitioner**, in the practice of the **practitioner’s** profession, that relates to a person other than a person under the **practitioner’s** care.”* While we understand that the guidelines must be accurate, and this sometimes requires the use of specific terminology, it can result in clunky and difficult reading making the guide less easily accessible. As an example, we suggest alternative wording as follows: *“conduct by a practitioner, while they are working, that relates to someone other than their patient or client.”*

Is the structure of the draft guidance logical and easy to follow? If not, what changes would help improve this?

We recommend that in setting out the categories of sexual misconduct, the examples should be numbered rather than bulleted. This will make referencing them in documents or legal submissions easier. For example:

1. violation by a practitioner of a professional boundary between the practitioner and a person under the practitioner’s care that could be considered sexual such as:
 - a. any of the following that is not clinically indicated –
 - i. touching, including stroking, caressing, or massaging;

instead of:

- 
- violation by a practitioner of a professional boundary between the practitioner and a person under the practitioner's care that could be considered sexual such as:
 - any of the following that is not clinically indicated
 - touching, including stroking, caressing, or massaging;

We recommend including an attachment or annexure to the draft Guidance that sets out:

- definitions of key terms, including grooming, sexual harassment, informed consent etc. in addition to those set out in the guidance
- Information about intersectional identities, and how they can increase risk of marginalisation and risk of experiencing sexual harm
- Key points that highlight and support understanding of information in the Guidance, specifically in infographic format

Is the process that the National Boards and Ahpra follow to lawfully publish the additional information on the public register clear? If not, please tell us what was not clear, and what changes could be made to make it more understandable.

We consider the process to be clearly set out, while noting our earlier comments regarding the importance of obtaining diverse perspectives.

Is our explanation of the categories of sexual misconduct clear in the draft guidance? If not, how can we improve this?

In relation to the wording of specific categories, we have outlined our recommendations below. These proposed changes aim to clarify definitions and broaden the scope of conduct that may be considered sexual in nature. While we understand the intent of the guidance is to keep definitions broad so as not to inadvertently exclude issues that would otherwise constitute misconduct, we are concerned that by not providing sufficient definitions of what constitutes elements of sexual misconduct, the opposite may result – that registered health practitioners will be left to interpret these terms based on misunderstood concepts, myths, and misconceptions. The lack of specificity also introduces ambiguity in the upholding of these definitions and introduces more scope for arguing what

‘is’ or ‘isn’t’ counted in ways which could unintentionally benefit perpetrators. This is especially the case for terms that can have multiple definitions, depending on context (jurisdictional, legal, therapeutic etc.).

As the purpose of the Guidance is to support practitioners in determining what constitutes sexual misconduct, broader explanations will likely result in greater consistency in understanding. We note, for example, that the draft Guidance states, *“‘Sexual misconduct’ is a broad term which encompasses the wide range of behaviours that fall within the **ordinary** meaning of the term.* However, it’s arguable we don’t have an “ordinary” meaning of this term, especially when taking into account cultural contexts, and widespread misunderstanding of important ancillary terms like “grooming” and “harassment.” Gift giving is often overlooked as a sign of grooming or sexual harassment, that is not apparent on the face of an “ordinary” definition.

In addition to the examples in the draft Guidance, and the recommendations we make below, we also suggest:

- Including more information/detail about what fully informed consent entails, taking into account intersectionality, marginalisation and stigmatised life experiences of patients/clients
- All examples also include an “attempt” to engage in any of the listed behaviour, regardless of whether it resulted in sexual harm to a patient/client or not

From	To
conducting an intimate physical examination without properly informed consent	conducting an intimate physical examination, or any physical examination or touch , without properly informed consent
conveying a desire or willingness to enter a sexual relationship	conveying a desire or willingness to enter a sexual, intimate or de-facto/spousal/partnership/dating relationship and/or sexual activity, including but not limited to declarations of affection, sexual innuendo, love and/or attraction

Sexual exploitation, abuse or harassment

- Sexual exploitation **refers to the abuse of a position of power or trust for sexual purposes**
- **Sexual abuse refers to any actual or attempted sexual activity that is unwanted, non-consensual, or exploitative. This includes situations where consent is absent, cannot be freely given (due to age, incapacity, coercion, threats, manipulation, power imbalance, or where sexual services are exchanged for benefit or gain), or is not proactive and enthusiastic. Sexual abuse can involve physical contact, non-contact acts (such as sexual comments or exposure), or digital/online behaviours (such as image-based abuse, grooming, or sexual exploitation).;** or
- **Sexual harassment refers to any unwelcome sexual behaviour that could reasonably be expected to make a person feel offended, upset, hurt, afraid, humiliated, or intimidated, and that is inappropriate in the circumstances. It may be verbal, physical, written, visual, or digital, and can occur as a single incident or a repeated pattern of behaviour.**

using digital platforms, including social media, to send inappropriate messages, images, or solicitations of a sexual nature to patients/clients	using digital platforms, including social media, to send inappropriate messages, images, or solicitations of a sexual nature to patients/clients and/or colleagues, peers, or co-workers. (For clarity, this also includes sending inappropriate messages, images, or solicitations of such a nature to a third party, regardless of whether the intent was for the subject of the message to ever receive/see it)
conduct that facilitates or attempts to facilitate a sexual act or formation of a sexual relationship ('grooming'), including by contacting the person electronically or via social media	conduct that facilitates or attempts to facilitate a sexual act or formation of a sexual relationship child sexual abuse, sexual exploitation, and/or sexual assault ('grooming'), including by contacting the person electronically or via social media. (For clarity, "grooming" is a deliberate pattern of behaviour used to gain the trust of a person, their family, or supporters to enable eventual sexual exploitation, abuse, or harassment. While individual acts in the grooming process may not be sexual in nature and may appear to be positive, the overall pattern is manipulative and exploitative, designed to build trust, create secrecy, and erode boundaries)

workplace sexual abuse, harassment, or impropriety	workplace sexual abuse, harassment, or impropriety, including punishing or victimising a person for speaking out against such behaviour. Impropriety includes behaviours that are inappropriate, not in accordance with accepted standards of conduct, are immoral or unethical. (Note: “sexual harassment” is defined above)
conduct that constitutes a criminal offence, whether committed in connection with the practice of the practitioner’s profession or not.	conduct that constitutes a criminal offence, or breach of civil provisions under a relevant law (i.e. the Fair Work Act 2009, relevant Federal anti-discrimination legislation, State based Work Health and Safety legislation), whether committed in connection with the practice of the practitioner’s profession or not, including sexual assault, offending that relates to child sexual abuse – including a failure to report – trafficking, and online offending
The behaviour may be sexual misconduct whether or not the practitioner has been charged with, pleaded guilty to, was found guilty of, or was convicted of a criminal offence.	The behaviour may be sexual misconduct whether or not the practitioner has been charged with, pleaded guilty to, was found guilty of, or was convicted of a criminal offence, or was found on the civil standard of proof to have

	breached provisions of a relevant law, as listed above.
The above examples highlight the importance of context, power dynamics, and the need for clear professional guidelines to protect both patients/clients and practitioners.	The above examples highlight the importance of context, power dynamics, and the need for clear professional guidelines to protect both patients/clients and their families, practitioners, peers and co-workers, and members of the public.
If a tribunal finds a practitioner guilty of professional misconduct involving an element of sexual misconduct, the following will be published on the public register: • A statement that the practitioner engaged in sexual misconduct • Any penalties or sanctions (like a reprimand, imposition of conditions, suspension or cancellation of registration) • A link to the tribunal's decision (if available).	If a tribunal finds a practitioner guilty of professional misconduct involving an element of sexual misconduct, the following will be published on the public register: • A statement that the practitioner engaged in sexual misconduct • Any penalties or sanctions (like a reprimand, imposition of conditions, suspension or cancellation of registration) • A link to the tribunal's decision (if available) • Referral information to appropriate sexual assault and counselling support services, men's behavioural change programs, and child sexual abuse offender services

Categories of sexual misconduct specific to marginalised populations

We suggest that it is necessary for the draft Guidance to unpack in more detail the nuanced ways sexual misconduct can play out for communities who experience marginalisation. To illustrate what we mean by this, we have provided two examples relating the LBGTQIA+ communities and

people with disability below as an indication of how nuanced and critical differences arise and should be integral to practitioners understanding of the content in scope of this guide. In addition to the example below, these groups should include, but are not limited to:

- Aboriginal and Torres Strait Islander people
- People with disability, particularly disabilities that may impact on their ability to provide fully informed consent, or disabilities that make them reliant on others who may exploit that relationship – adults with severe or profound disability (24%) were about 3 times as likely as adults without disability (9.6%) to report they had experienced sexual violence since the age of 15.²
- People who speak a language other than English as a primary language
- People whose religion, culture or customs prevent or inhibit them from either questioning people they perceive to be in positions of power or authority over them or having different cultural understandings about what constitutes sexual misconduct or what is 'normal' or 'appropriate' within a relationship with a health practitioner
- People who are experiencing or at risk of domestic, family, or sexual violence
- Children and young people, specifically those with intersecting marginalisations, including being in out of home care, in the justice system, First Nation, children with a disability, or children who are LGBTIQ+ and/or trans and gender diverse (TGD) – 37% of Australian women and 19% of Australian men over the age of 16 have experienced sexual abuse as a child.³

² Australian Institute of Health and Welfare. (2024). *People with disability in Australia*. Retrieved from <https://www.aihw.gov.au/reports/disability/people-with-disability-in-australia>

³ Haslam, D., Mathews, B., Pacella, R., Scott, J. G., Finkelhor, D., Higgins, D. J., Meinck, F., Erskine, H. E., Thomas, H. J., Lawrence, D., Malacova, E., & Dunne, M. P. (2023). *The prevalence and health impact of child maltreatment in Australia: Findings from the Australian Child Maltreatment Study (Brief Report)*. Australian Child Maltreatment Study, Queensland University of Technology. https://www.acms.au/wp-content/uploads/2023/04/3846.1_ACMS_A4Report_C1_Digital-Near-final.pdf

- People who are LGBTIQ+ and/or TGD – for example, adults who are TGD are more likely to have experienced child maltreatment – including CSA – compared to the rest of the population.⁴
- Older people, particularly those in aged care or other institutional settings, or those at risk of elder abuse
- Sex workers
- People living in rural and remote locations, specifically where there are limited health services available locally
- People on temporary visas
- People who experience poverty, are reliant on government assistance, and may find it difficult to financially access health care and treatment
- People who are displaced by disaster or crisis, including floods and natural disasters

If this draft Guidance is intended to serve as a primary source of information for registered health practitioners, it must include significantly more detail on working with and interacting with such marginalised groups. While we recognise the value of brevity in some circumstances, it is inappropriate in this guidance to ignore the complex risks of harm to highly vulnerable people. Statistics in a multitude of other related settings say those who experience these types of vulnerabilities are frequently at risk of and do experience additional exacerbated risk of harm, including sexual harm. We suggest that the draft Guidance be lengthened to include information about intersectionality and marginalisation – as listed above – even if it means the document becomes lengthy. We suggest that as the draft Guidance is directed at registered health practitioners – professionals who are highly educated and bound by obligations to uphold their professional responsibilities, duty of care, and registration requirements – a more comprehensive and substantive document is essential.

⁴ Higgins, D. J., Lawrence, D., Haslam, D. M., Mathews, B., Malacova, E., Erskine, H. E., Finkelhor, D., Pacella, R., Meinck, F., Thomas, H. J., & Scott, J. G. (2024). *Prevalence of diverse genders and sexualities in Australia and associations with five forms of child maltreatment and multi-type maltreatment*. *Child Maltreatment*, 30(1), 21–41.
<https://doi.org/10.1177/10775595231226331>

Case study example: Categories of sexual misconduct pertaining to LGBTQIA+ people

We notice the absence of tailored guidance in relation to LGBTQIA+, intersex, and trans and gender diverse (TGD) people and specific issues they face that differ from cis gendered and heterosexual people in this section of the document. This seems an oversight given that LGBTQIA+ and TGD people often rely on scarce, specialised health care (e.g. gender-affirming care, HIV treatment, fertility, sexual health) while also facing higher risk of bias, discrimination, and marginalisation more generally, and thus the risk of coercion is heightened. According to the most recent national survey of LGBTQIA+ experiences of sexual violence, 75% of respondents had experienced sexual violence during their lifetimes, with 34% having experienced sexual abuse as children (56% among First Nations respondents) and 52% having experienced sexual violence both as children and as adults.⁵ The Australian Child Maltreatment Study showed the prevalence of child maltreatment experienced by sexuality diverse Australians was significantly higher compared to heterosexuals for each type of maltreatment – physical abuse, sexual abuse, emotional abuse, neglect, exposure to domestic and family violence – but particularly so for sexual abuse (51.9% compared to 20.01%).⁶

Sexual misconduct in medical settings affecting queer communities can blend sexual exploitation with discrimination, fetishisation,⁷ or transphobia/homophobia, often under the cover of clinical authority. For examples:

⁵ Salter, M., Breckenridge, J., Lee-Ah Mat, V., Kaladelfos, A., Whitten, T., Suchting, M., Breckenridge, V., Dubler, N., & Griffin, A. (2025). *National Survey of LGBTQIA+SB Experiences of Sexual Violence: Report 1 – Prevalence, attitudes and lifetime experiences*. UNSW Sydney. <https://www.unsw.edu.au/content/dam/pdfs/ada/gvrn/research-reports/2025-02-GVRN-LGBTIQA-SB-National-Survey-Report-1.pdf>

⁶ Higgins, D. J., Lawrence, D., Haslam, D. M., Mathews, B., Malacova, E., Erskine, H. E., Finkelhor, D., Pacella, R., Meinck, F., Thomas, H. J., & Scott, J. G. (2024). *Prevalence of diverse genders and sexualities in Australia and associations with five forms of child maltreatment and multi-type maltreatment*. *Child Maltreatment*, 30(1), 21–41. <https://doi.org/10.1177/10775595231226331>

⁷ **Fetishisation** in relation to LGBTQIA+ cohorts refers to the act of reducing people to their sexual orientation, gender identity, or expression for the purpose of objectification or sexual gratification, often disregarding their full humanity, individuality, and lived experiences.

- Unnecessary or invasive physical examinations framed as “medical,” but targeting sexual organs or secondary sex characteristics in ways that are inappropriate or prurient.
- Sexualised comments or jokes about a sex, gender identity, transition, or sexual orientation.
- Uninvited questions about sexual practices framed as “curiosity” or “relevant” but irrelevant and unnecessary to the presenting medical issue.
- Misuse of medical authority and scarcity of access to TGD health care to coerce sexual favours (e.g. implying care, hormones, surgery access, or referrals are conditional on sexual compliance).
- Mocking or fetishising trans or queer identities (e.g. suggesting trans women are “really men,” or sexualising lesbian identity).
- Using clinical settings for voyeurism — deliberately seeking to examine queer/trans patients for gratification.
- Persistent misgendering or derogatory language combined with sexualised undertones (e.g. referring to a trans man by slurs while commenting on his chest or genitals).
- Exploitative “counselling” or conversations where the practitioner pressures the patient to disclose sexual history in ways that are irrelevant and intrusive.

While the above is content we believe should be included in the draft Guidance in some form, we also encourage Ahpra to ensure such content is reviewed by LGBTQIA+ and TGD people and practitioners.

Case study example: Categories of sexual misconduct pertaining to people with disability

People with disability – whether physical, sensory, intellectual, or psychosocial – face heightened risks of boundary violations in health care due to systemic power imbalances, dependency on caregivers, and societal biases like ableism. People with disability are disproportionately impacted by sexual violence, with national data showing significantly higher rates of harm compared to the general population. The *‘Nature and*

extent of violence, abuse, neglect and exploitation against people with disability Australia' report found:⁸

- people with disability are at 2.2 times the risk of sexual violence in comparison to people without disability,
- young women with disability (18–29 years) are twice as likely to report experiencing sexual violence over their lifetime than young women without disability
- men with disability are 2.6 times as likely to report sexual violence compared to men without disability

Case Study – Boundary Violation in Disability Care

A 30-year-old woman with cerebral palsy who uses a wheelchair and personal care support, attends regular physiotherapy. Her therapist, aware of her physical dependency, begins making overly personal comments about her appearance during sessions, progressing to unnecessary physical contact under the guise of “adjusting” her posture. The patient, who uses a communication device, feels uncomfortable but fears reporting due to her reliance on the service and prior experiences of being dismissed as “overreacting.” The practitioner’s actions escalate over months, exploiting her limited mobility and isolation.

This case study shows how sexual misconduct can be disguised behind the guise of genuine medical touching or intervention. It also highlights how boundary violations commence, and then incrementally escalate. Even if the patient discloses feeling uncomfortable, it is likely she’ll be told the touching was in accordance with her treatment.

Sexual misconduct against people with disability can take many forms, and present in different ways. Disability is not a monolith, and takes numerous forms, all of which can be exploited to varying degrees. For example,

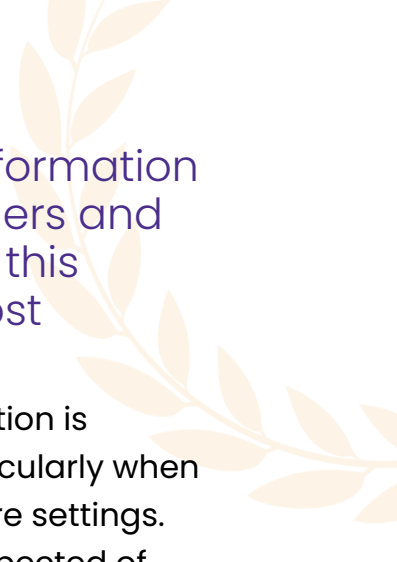
- **Inappropriate touching**, whether of a sexual nature or not, under the guise of “legitimate” medical interventions

⁸ **Disability Royal Commission.** (2021, March 16). *People with disability face much greater risk of violence than people without disability* [Press release]. Retrieved August 14, 2025, from <https://disability.royalcommission.gov.au/news-and-media/media-releases/people-disability-face-much-greater-risk-violence-people-without-disability>

- **Medical gaslighting**, which includes dismissing or invalidating a patient's symptoms as "all in their mind," and undermining their confidence in their own perceptions
- **Medical overshadowing**, which attributes symptoms to a disability or mental health condition without proper investigations
- **Threats of involuntary psychiatric admission** when a patient raises concerns about inappropriate or unprofessional conduct

Medical gaslighting, medical overshadowing, inappropriate touch and threats may not always amount to sexual misconduct. However, for people with disability, who may already face societal stigma or self-doubt due to ableism, this can make it harder to recognise or challenge inappropriate behaviour. These behaviours make people with disability more vulnerable to sexual misconduct by eroding trust, exploiting dependency, normalising boundary crossings, and leveraging coercive threats like psychiatric sectioning. For people with disability, this can be particularly acute due to systemic ableism, dependency on care, and historical mistrust of medical systems, as seen in cases of forced institutionalisation. We make the following recommendations in relation to the Guidance, noting that genuine collaboration should occur with an organisation like People with Disability Australia and Women with Disability Australia for further and refined input:

- Strengthen anonymous reporting mechanisms and anti-retaliation protections
- Standardise sanction guidelines with objective criteria and increase community member involvement in panels
- Mandate boundary-awareness training that emphasises ethical touch and informed consent
- Prohibit threats of involuntary psychiatric admission
- Enhance data collection and research in misconduct reports to track and address gaps
- Focus on broader cultural shifts, and incorporate anti-bias simulations into medical education, and ongoing professional development



In addition to FAQs, is there any other type of information or resource we could develop to help practitioners and the public better understand the publication of this additional information? If so, what would be most helpful?

Access to clear, accessible and culturally appropriate information is essential to empowering health consumers and patients, particularly when it comes to the serious issue of sexual misconduct in healthcare settings. Many people may be unaware of their rights, the standards expected of registered health practitioners, or how to raise concerns safely. Ensuring that this information is tailored to the needs of diverse communities, including those with language, literacy, disability and cultural considerations, is critical to building trust and encouraging help seeking. Beyond FAQs, a broader suite of resources should be developed to support understanding among both the public and practitioners.

Plain English and Multilingual Resources

Written materials should be produced in plain English, formats accessible by assistive technology like screen readers and magnifiers, and translated into multiple languages, with meaningful input from people within those communities to ensure cultural relevance and clarity. Consideration should also be given to people with cognitive or communication disabilities in relation to the accessibility/intelligibility of all materials. This would improve accessibility for both health consumers and practitioners from diverse backgrounds.

Information Displayed in Health Settings

Educational resources (including posters etc.) about what constitutes sexual misconduct in this context and information about complaints processes should be visibly displayed on the premises of registered health practitioners and within consultation rooms, and include reporting information. This helps normalise conversations about safety and empowers patients to understand their rights and options.

Resources Available in Sexual Assault Counselling and Support Services

Information about the complaint process and publication of misconduct findings should also be available in settings where people who have

experienced sexual harm are likely to seek support. This ensures that survivors can access relevant information in a trusted environment. The release of the Guidance should occur in conjunction with a public campaign to raise awareness, provide information about accessing support, and complaint mechanisms.

Compulsory Training and Education for Registered Health Practitioners

Ahpra should introduce compulsory, ongoing training for all registered health practitioners, informed by the mandatory sexual harassment training for legal practitioners in Tasmania. This training should:

- Be conducted live (not pre-recorded)
- Promote open discussion and critical reflection, specifically within professions that have strong hierarchical cultures like medicine
- Address power dynamics, the impact of gender, child sexual abuse, and common myths about sexual assault and harassment
- Unpack intersectional factors that may increase risk to marginalised cohorts, such as the LGBTIQ+ community, Aboriginal people, people with disability, members of culturally and ethnically diverse groups, age groups – including children and older people, and gender – including trans and gender diverse people.
- Provide guidance that supports workplaces to incorporate content into workplace policies, procedures, and cultures to support lasting organisational change
- Be a requirement for processes like registration
- Be delivered regularly (not one-off)
- Help embed a culture that respects and encourages people to speak out against sexual misconduct, including patients/clients, and employees, colleagues and peers
- Provide resources for working with specific marginalised populations
- Include realistic case studies to support people in identifying inappropriate behaviour

Training on issues like grooming and sexual harassment must account for widespread misunderstanding within the community about what these behaviours look like. This confusion can be exacerbated by the fact that legal definitions vary across legal jurisdictions, as well as differences in how terms are used within therapeutic or support-based settings. For example, “grooming” is defined in Tasmania’s Criminal Code as a form of

communication, while in practice it's more often understood as a pattern of behaviour. These differences matter, especially given that fewer than half of adults can recognise common grooming behaviours.⁹

Training must be clear about its purpose, avoid over-reliance on legal definitions, and be designed to challenge myths, stereotypes, and biases. Crucially, it should be interactive and support a culture where people feel safe and confident to speak out.

Co-design of Training, Education and Resources

All training, education, and resources should be co-designed with people who have lived experience of sexual harm from a registered health practitioner or other relevant lived expertise, and specialist sexual violence providers. This process must follow a trauma-informed approach that prioritises safety, choice, and genuine collaboration. It is essential that the co-design process includes a diverse range of lived experiences, reflecting differences in gender, culture, disability, professional background, and settings in which harm has occurred, and ensure the content is relevant, inclusive, and responsive.

Do you have any other feedback that you would like to provide?

Changes to Website Advice

We strongly recommend that Ahpra reconsider any guidance that encourages individuals to raise concerns directly with a health service or practitioner as a first step in the complaints process where that concern relates to sexual misconduct. In such cases, this approach is not appropriate and may place victim-survivors at risk of further harm, intimidation, or re-traumatisation. This is particularly the case where the victim-survivor may have scarce access to that health support and thus be reliant upon it with limited alternatives, placing them in a highly precarious situation should they raise the complaint directly.

⁹ National Centre for Action on Child Sexual Abuse. (2024, October). *The Australian child sexual abuse attitudes, knowledge and response study: Report 1: Top line findings*.

National Centre for Action on Child Sexual Abuse. https://nationalcentre.org.au/wp-content/uploads/2024/10/Community-Attitudes-Study_Report-1_Oct-2024.pdf

Various Reporting Pathways

People should have safe, accessible, and culturally safe reporting pathways. For example, many people with disability face barriers like inaccessible complaint forms (e.g., non-Braille, complex language) or rely on intermediaries to complete documents and paperwork on their behalf. The ability to commence a complaint needs to be provided in multiple formats, for example, including Easy Read, Auslan-interpreted videos, and advocate-supported reporting.

Trauma-Informed Care

Trauma-informed, person-centred care should sit at the heart of all aspects of the complaint process. This starts with the availability of appropriate and sensitive resources and information, interactions with Ahpra and other National Bodies, through to tribunal and court processes. Where a practitioner has a substantiated finding of sexual misconduct recorded on their public register entry, Ahpra should include information about how to access relevant counselling and support services, and/or how to make a complaint alongside that entry. If someone is searching the register for information about a registered health practitioner, it may be because the practitioner has offended against other people and/or has continued to engage in sexual misconduct. In such cases, it is important that appropriate information and support options are readily available at that point of access.

Appropriate referral information to sexual assault counselling and support services should also be included in the Guidance document, and in any other documents or correspondence provided to a complainant throughout the complaint process. This is especially important given the length of delays in some matters being finalised, and that victim-survivors may need different support(s) throughout the process.

Lived Experience Embedded in Decision Making

We encourage Ahpra and National Boards to ensure that lived experience is embedded at all levels of decision-making related to the identification, assessment, and investigation of sexual misconduct. It is essential that this lived experience includes a diverse range of perspectives, including

but not limited to people of different genders, sexual orientations, cultural backgrounds, socioeconomic backgrounds, disabilities, and experiences of institutional harm. Without this, there is a risk that definitions and processes will reflect a narrow or clinical understanding of harm, rather than the complex and often intersectional realities faced by victim-survivors.

Additionally, we note that Ahpra Boards are typically comprised of a combination of relevant practitioners and community members. While professional expertise is crucial, it is imperative that, to the greatest extent possible, community members appointed to Ahpra boards have diverse lived experiences. This is especially the case for the Ahpra board who oversees sexual misconduct complaints. Ensuring diverse representation and independent oversight, particularly when addressing issues as serious as sexual misconduct, is vital to building trust, fairness, and accountability in the regulatory process.

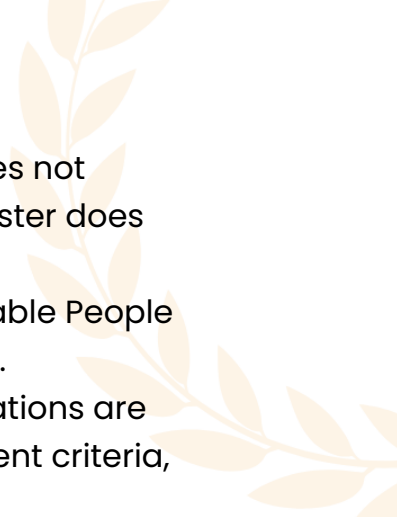
We also highlight the importance of embedding lived experience in the complaint investigation phase at Ahpra, in a structure similar to that of a medical expert panel. This approach would support the early identification of sexual misconduct and ensure it is meaningfully incorporated into the recommendations made to Boards.

WWVP/WWCC Registration not Disclosed on Ahpra check

Case Study – Medical Doctor Working Without WWVP Registration

Laurel House is aware of a medical doctor working in Tasmania who had their WWVP registration suspended. Their employer was aware of the suspension, but as this change was not noted on their AHRPA registration, there was no legal pathway for patients to be informed. The employer made changes to the doctor's duties, so they could not treat children or vulnerable people (noting that the employer would not have sufficient information in all cases to know which clients experience vulnerability), but this change was not communicated to the doctor's colleagues, or to patients.

While we recognise Working with Vulnerable People (WWVP) / Working with Children Check (WWCC) registration is outside the scope of this consultation, we note that while the National Register provides important information about a practitioner's registration status – such as any



conditions, undertakings, suspensions, or cancellations – it does not include other key risk-related information. Specifically, the register does not disclose whether a practitioner has a criminal history, their employment history, or their status under Working with Vulnerable People (WWVP) or Working with Children Checks (WWCC) registration. It is also important to acknowledge that WWVP/WWCC registrations are administered separately in each state and territory, with different criteria, processes, and oversight bodies and often flawed systems for interjurisdictional sharing of changes in registration status. These schemes are not managed by Ahpra, and there is currently no automatic alignment between Ahpra registration and WWVP/WWCC approval. As a result, a practitioner may hold Ahpra registration without holding a valid WWVP or WWCC clearance, and vice versa. This lack of integration between regulatory systems creates gaps in public protection as shown in the case study above and lead to confusion for patients, employers, and members of the community who assume that registration equates to full vetting. Improving transparency and coordination between these systems would be a valuable step toward strengthening safeguards and public trust. We suggest that, at a minimum, registered health practitioners should have to be registered for a WWVP/WWCC, consistent with registration for teachers across Australia.

Registration of Other Health Practitioners

We note that there are currently a significant number of health practitioners who are not required to be registered with Ahpra. This includes speech pathologists, dieticians, audiologists, exercise physiologists, sonographers, social workers, along with several others. Although outside the scope of this review, we make the point that these health practitioners, should they be registered by Ahpra at a later point, they be subject to the same reforms.

Unintended Consequences

While we strongly support robust mechanisms for identifying and addressing sexual misconduct, we also urge Ahpra and the National Boards to remain alert to potential unintended consequences in the implementation of this guidance. In particular, it is important to acknowledge the risk of malicious or vexatious complaints being used to unfairly target registered health practitioners, especially in highly

feminised professions such as nursing (female 87.9%, male 12.01%),¹⁰ occupational therapy (female 89.5%, male 10.5%),¹¹ pharmacists (female 63.8%, male 36.2%),¹² and physiotherapists (65.6% female, 34.4% male).¹³ While these statistics are recorded on a gender binary between male/female, we want to acknowledge that gender is in no way a binary and representing it as such denies the identities of a vast range of people in the trans and gender diverse community who will be part of these statistics and indeed likely to be at even greater risk of harm in such settings given general statistics about the severe marginalisation and oppression of those communities.

Experience from the family violence sector, including insights from local legal practitioners, highlights cases where Ahpra complaints have been weaponised against victim-survivors of family and domestic violence—particularly in situations where they have been misidentified as the predominant perpetrator. In the vast majority of cases, those who are misidentified are women victim-survivors. According to Engender Equality (2022), there is now a growing body of research to suggest that women are being misidentified as predominant aggressors in increasing numbers. They state:

“In 2014, a study by Women’s Legal Service New South Wales reported that two-thirds of women who had been identified as predominant aggressors were victim-survivors...In 2018, a study by Women’s Legal Service Victoria reported that one in ten women who

¹⁰ Australian Nursing and Midwifery Federation. (n.d.). *Nursing and midwifery workforce overview* [PDF]. Retrieved from https://www.anmf.org.au/media/rixjepl5/nursing-and-midwifery-workforce-overview.pdf?utm_source=chatgpt.com

¹¹ Australian Health Practitioner Regulation Agency. (2023). *Occupational therapists: A snapshot as at 30 June 2023* [PDF]. Retrieved from URL

¹² Australian Health Practitioner Regulation Agency. (2022). *Pharmacy workforce analysis as at 30 June 2022* [PDF]. Retrieved from <https://www.ahpra.gov.au/documents/default.aspx?chksum=%2BkCL%2FgZyo3ahYxDzvt%2Btbw%3D%3D>

¹³ **Physiotherapy Board of Australia. (2021, November 22).** *2019/20 annual summary*. Retrieved from https://www.physiotherapyboard.gov.au/News/Annual-report/2020-annual-summary.aspx?utm_source=chatgpt.com

were victim-survivors had been misidentified as predominant aggressors”¹⁴

Being misidentified as the predominant perpetrator means that a person, often a victim-survivor, is incorrectly labelled by police or the legal system as the main aggressor in a domestic or family violence incident. This misidentification can occur when:

- A victim uses defensive violence or resists abuse, which is then misinterpreted as primary aggression.
- The actual perpetrator manipulates the situation to appear as the victim.
- Police respond to incidents using a "he said, she said" approach without considering the broader pattern of coercion or control.

In some cases, the predominant aggressor exploits regulatory systems – often referred to as “systems abuse,” by making false or exaggerated complaints to Ahpra against their current or former spouse or partner, who is a registered health practitioner. The intention is to damage the victim’s professional reputation and potentially affect their registration to work. Because the complaint may initially appear legitimate, the misidentified victim-survivor faces further harm through investigations or sanctions, compounding the abuse and reinforcing the perpetrator’s control. This underscores the importance of fair and trauma informed processes, informed by lived experience.

We acknowledge that systems abuse – as set out above – and using reporting or complaint proceedings against a registered health practitioner with malicious intent, can occur in other circumstances outside of the family and domestic violence context. For example, when motivated by discrimination or prejudice, including sexism, racism, ableism, homophobia or transphobia, or ageism. This may include circumstances where the registered health practitioner experiences marginalisation themselves, including on the basis for disability, race, or

¹⁴ Engender Equality. (2022). *Misidentification of the predominant aggressor in Tasmania: Practitioner perspectives from Engender Equality* [Research discussion paper]. Engender Equality. <https://engenderequality.org.au/wp-content/uploads/2023/07/Engender-Equality-Misidentification-of-the-Predominant-Aggression-Research-Discussion-Paper-2023.pdf>

other social circumstance like being on a temporary visa. We encourage Ahpra and the National Boards to be alive to this possibility in determinations regarding findings of sexual misconduct.

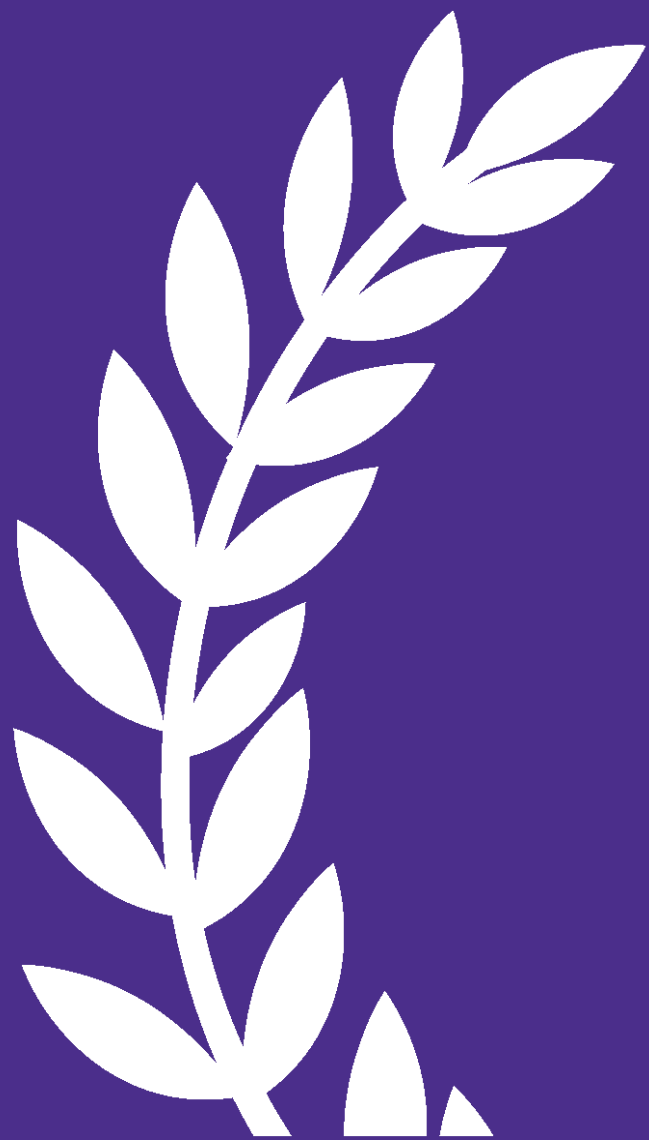
Rehabilitation Pathways

While we support the recording of sexual misconduct on a registered health practitioner's record, we also acknowledge the individual and societal benefits of genuine accountability and rehabilitation for those who have previously engaged in such behaviour. A significant component of Laurel House's work lies in primary prevention – through education and advocacy – which is essential to reducing sexual harm. Given the current prevalence of sexual harm in our society, it is clear that punitive measures alone are insufficient. In addition to holding offenders to account, we must also make space – where it is safe, appropriate, and consultative with the victim-survivor – for rehabilitation. Accordingly, we recommend that Ahpra consider incorporating clear rehabilitation pathways and periodic review mechanisms for non-recidivist offenders within its regulatory framework.

We note that the term “*non-recidivist offenders*” relates only to *not being caught* again, rather than not offending again. We therefore suggest that there should be an additional requirement that includes a risk assessment, which takes into account the marginalisation and vulnerability of patients/clients.

Conclusion

We welcome the draft Guidance as an important step toward safeguarding public trust and safety in health care. Moving forward, embedding diverse lived experiences and trauma-informed approaches in decision-making will be key to ensuring fairness and effectiveness. To achieve meaningful reform, adequate resourcing is essential, along with comprehensive training, education, and clear guidance on the application of new standards. Strengthening coordination across regulatory systems and extending protections to all health practitioners will further enhance public confidence. We look forward to ongoing collaboration to build a safer, more accountable health sector.



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