



Standards of Practice Manual for Services Against Sexual Violence

(3rd Edition)



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The Standards of Practice Manual for Services Against Sexual Violence (3rd edition) was prepared for the Department of Social Services.

The Third Edition was prepared by the Gendered Violence Research Network, School of Social Sciences, UNSW Sydney, for the National Association of Services Against Sexual Violence (NASASV).

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Foreword

National Standards of Practice Manual for Services Against Sexual Violence (Third Edition)

National Association of Services Against Sexual Violence (NASASV) is the key expert Peak Body in Australia for sexual violence and has been in operation as a national group since 1987. The Association is represented by sexual assault services in each Australian State and Territory and works to implement the shared aims of sexual assault services for those who are impacted by sexual violence, in all of its forms, with the ultimate goal of eliminating sexual violence in our communities.

NASASV's position is that sexual violence is an abuse of power, most often perpetrated by men against women, children, young people and other men. It is both a consequence and a reinforcement of power disparities between individuals and groups in society. Attitudes, beliefs, laws and social structures which allow or support the power of one group over another, or allow or support violence to continue, contribute to the ongoing problem of sexual violence in society.

Given the high incidence of sexual violence, all sectors of the community, including governments and key organisations such as NASASV, must work towards its elimination and the provision of effective responses for those impacted.

Sexual violence can result in a range of serious, potentially long-term consequences for the individual and society, including physical, emotional, financial, social, legal, political and spiritual consequences. These impacts can be compounded by inequalities resulting from gender, race, culture, age, religion, ability, sexuality, language, class and geographic location.

NASASV is committed to addressing inequalities in society which perpetuate sexual violence, whilst working collaboratively with service systems and communities to ensure that prevalence rates of sexual assault reduce. NASASV is further committed to ensuring that people sexually assaulted in Australia are appropriately responded to and supported by systems and communities.

NASASV works towards the empowerment of those impacted by sexual violence by:

- Ensuring that the views of those impacted by sexual violence are sought and used to influence service provision and policy direction
- Promoting the rights of those impacted by sexual violence through the provision of information, options and choices, and
- Ensuring that decisions about accessing support, advice and justice are in the hands of the person seeking assistance

In assisting those living with the effects of sexual violence, Sexual Assault Services under the umbrella of NASASV recognise that the mental health impact of sexual violence is a traumatic reaction. Service provision is trauma informed and specialised, based on frameworks of international best practice for working with trauma and provided within a framework of quality assurance and continuous improvement.

This is a significant and timely opportunity for government to work with specialist sexual violence services in Australia. NASASV is well placed to ensure it can consistently and comprehensively contribute its expertise to Australia's reform efforts, and help to build quality, coordinated and robust responses to sexual violence across broader and connected systems. NASASV holds significant policy expertise and practice knowledge (over 34 years) that can help inform Australia's reform efforts. NASASV's expertise is also strengthened by its use of service user experiences in its advocacy work.

NASASV was engaged by the Department of Social Services (Commonwealth) in 2020-21 to develop a Third Edition of the National Standards of Practice Manual for Services Against Sexual Violence.

The Gendered Violence Research Network (GVRN) at the University of New South Wales was subsequently engaged by NASASV to work in collaboration to develop the new edition of the Standards.

GVRN undertook an extensive literature review to locate national and international standards, guidelines, and research produced over the five years since the Second Edition of the Standards was produced in 2015. Relevant findings from the literature review were incorporated into the Third Edition.

The Third Edition of the Standards of Practice Manual was reviewed by the NASASV Reference Group and a nationally-focussed Expert Advisory Panel, and tested via a national consultation process, with people with lived experience, practitioners, and experts.

NASASV last updated the National Standards for Services Against Sexual Violence in 2015. This was a collaborative effort from sexual assault services across Australia. The importance of knowing how to respond cannot be overstated. Knowing how to respond sensitively, being equipped with the right knowledge and skills, being confident in one's scope of practice and understanding where this begins and ends are important for appropriately responding to people against whom violence has been perpetrated.

The purpose of these Standards is to ensure accessible, high quality and consistent service provision. This Edition of the Standards provides guidance on the provision of services to adults, children and young people who have experienced sexual assault, and children and young people exhibiting harmful sexual behaviours.

The Standards will set a standard for practice competence for the workforce and provides guidance also for training providers on the design and development of different levels of training for responding to people impacted by sexual violence. These Standards address the specific skills and knowledge set required for different modalities of responding, such as telephone, online or face-to-face approaches.

On behalf of NASASV I commend to governments, organisations, services, and the wider community The National Standards of Practice Manual for Services Against Sexual Violence (Third Edition).

Joanne Sheehan-Paterson OAM

Chairperson

National Association of Services Against Sexual Violence

Acknowledgements

Aboriginal and Torres Strait Islander peoples

NASASV acknowledges Aboriginal and Torres Strait Islander peoples as Australia's First Nations and Traditional Owners and custodians of Country. We pay respects to Elders past and present. We acknowledge that sovereignty was never ceded and recognise continuing connection to land, waters, and culture.

NASASV acknowledges that family violence, substance misuse, sexual assault, and abuse disproportionately impact Aboriginal and Torres Strait Islander women and children and trap some families and communities in cycles of crisis. The impact of colonisation and subsequent Commonwealth, State and Territory government policies have adversely affected Aboriginal and Torres Strait Islander communities and individuals. The legacy of colonisation can be seen in current experiences of systemic racism, poor health, multiple bereavements, and high levels of involvement in the criminal justice and child protection systems.

We acknowledge the work of Aboriginal and Torres Strait Islander peoples over many decades in Australia, who have articulated to governments and services at every opportunity the relationship between colonisation and intergenerational trauma and current high rates of sexual and gendered violence in Aboriginal and Torres Strait Islander Communities. They have also shared the strengths of their cultures in responding to sexual violence and the capacity of cultural practices to offer Aboriginal and Torres Strait Islander people healing and foster their recovery. We recognise that adequate supports and responses to trauma developed with Aboriginal and Torres Strait Islander communities are critical to keeping Aboriginal and Torres Strait Islander communities safe.

Acknowledgement of Lived Experience

In these Standards, we draw on research relating to experiences of violence and abuse. Statistics are an important tool for understanding, but the figures can seem depersonalised.

It is important to remember that there is a real person impacted by each act of violence represented in any data presented in these Standards. The ripple effect of the act/s of violence may spread to their families, friends, workplaces and communities. Stories of survival, hope and resistance sit alongside stories of victimisation.

Contributors

This edition of the Standards has been overseen by a Steering Committee of NASASV members. NASASV convened an Expert Advisory Group (EAG) of professionals and practitioners from around Australia to provide input on the Literature Review, an early draft of the Standards and the final draft. Over 100 organisations working in the specialist sexual violence field from around the country were consulted on the final draft. Two consultation groups were held virtually, so that input could be obtained from more practitioners. One organisation provided written and verbal feedback. All feedback was noted and actioned where possible, producing a final version we believe is reflective of the practice and philosophy of specialist sexual violence services in Australia.

Glossary

Aboriginal and Torres Strait Islander peoples: Aboriginal and Torres Strait Islander peoples are the first inhabitants of Australia. The definition accepted by Aboriginal and Torres Strait Islander peoples and the Federal Government defines an Aboriginal person as someone who:

- is of Aboriginal descent;
- identifies as an Aboriginal person; and
- is accepted as an Aboriginal person by the community in which he or she lives (Australian Institute of Aboriginal and Torres Strait Islander Studies, n.d.).

Aboriginal peoples comprise diverse Aboriginal nations, each with their own language and traditions and have historically lived on mainland Australia, Tasmania or on many of the continent's offshore islands. Torres Strait Islander peoples come from the islands of the Torres Strait, between the tip of Cape York in Queensland and Papua New Guinea (Australian Human Rights Commission, 2005). See also **First Nations**, which is the term preferred by some Aboriginal and Torres Strait Islander peoples and groups.

Advocacy: Advocacy refers to a wide range of activities to promote, protect and defend victims' and survivors' human rights and their rights to services and information. It may involve assisting victims and survivors to express their own needs, access information, understand options and make informed decisions (Royal Commission into Institutional Responses to Child Sexual Abuse, 2017b).

Augmentative and alternative communication: Where natural speech cannot meet the communication needs of an individual, they may rely on augmentative or alternative communication technology (AAC). AAC refers to all types of communication other than oral speech (e.g., pictures, writing, symbols, hand gestures). AAC systems may be unaided (e.g., signing, gestures), or aided via technology (ego speech generating devices, mobile technologies) or nontechnology assistive products (e.g., communication boards/books) (National Academies of Sciences Engineering and Medicine, 2017).

Case management: Coordination of individual client care aiming to improve service access and provision. It aims to strengthen service provision when multiple services are delivering care to a client or family (NSW Government, 2020). Case management may occur independently of, or in conjunction with, clinical interventions.

Child safe organisations: Create a culture, adopt strategies and take action to promote child wellbeing and prevent harm to children and young people. They place emphasis on genuine engagement with children, value children and have implemented the National Principles for Child Safe Organisations (Australian Human Rights Commission, 2018).

Child sexual abuse: Any act which exposes a child to, or involves a child in, sexual processes beyond his or her understanding or contrary to accepted community standards (Royal Commission into Institutional Responses to Child Sexual Abuse, 2017b). Sexually abusive behaviours can include the fondling of genitals or breasts, masturbation, oral sex, penetration of the vagina or anus by a penis, finger or other object, voyeurism, exhibitionism, and exposing the child to or involving the child in pornography (Australian Institute of Health and Welfare, 2020b; Royal Commission into Institutional Responses to Child Sexual Abuse, 2017b). It also includes child grooming – see definition of Grooming.

Child sexual assault: Is a term commonly used to describe forms of child sexual abuse where a person has engaged in sexual activity with a child or young person, where there has been physical contact or intent of contact. In most jurisdictions in Australia, a child or young person cannot consent to sex if they are under 16 years of age (in South Australia and Tasmania, the age of consent is 17 years) (Australian Institute of Health and Welfare, 2020b).

Clinical interventions: In the context of sexual violence services, clinical interventions can be understood as any professional activity directed towards assessing, maintaining or improving the health of a client (Australian Institute of Health and Welfare, n.d.). The consent of the client and/or their caregiver (in the case of children, young people or those with a cognitive impairment) is required before any clinical intervention takes place. Depending upon the services provided by the organisation, examples of clinical interventions may include medical assessment, forensic medical procedures, face to face individual counselling, group work programs, and telephone and online counselling.

Clinical supervision: The purpose of clinical supervision is to support workers to provide high-quality care that is safe, confidential and empowering for people and their families. It encourages workers to reflect on their professional practice and build their skills in working with the complex and diverse impacts of sexual violence. Simultaneously, it aims to strengthen worker and agency resilience and mitigate the impacts of vicarious trauma (NSW Ministry of Health, 2019b).

Collaboration: In this context, collaboration is defined as health care professionals in different organisations assuming complementary roles based on their expertise and cooperatively working together in the best interests of the client (O’Daniel & Rosenstein, 2008).

Complex trauma: Refers simultaneously to complex forms of victimisation, involving repeated incidents of abuse and betrayal, and the complex traumatic and dissociative symptomatology that results from it (Salter et al., 2020).

Critical incident: A tragic or traumatic event or situation, or the threat of such, which affects or has the potential to affect staff and/or clients of a service in a traumatic way. Examples include death, attempted suicide, assault, and severe verbal or psychological aggression.

Cultural brokerage: A term used to reflect a role within services whereby an Aboriginal or Torres Strait Islander worker develops a relationship with clients and, where appropriate, their families, to build trust, facilitate engagement with the service and provide support. This role is in addition to, rather than a replacement of, standard clinical practice. The engagement is authentic and ongoing and aids in ensuring that the care and support provided to Aboriginal and Torres Strait Islander clients reflects a more holistic approach to service delivery, and incorporates a cultural dimension (McKenna, Fernbacher, Furness, & Hannon, 2015).

Cultural consultation: A process whereby clinical staff seek the input of a worker or elder from another cultural background in order to provide more appropriate care and treatment for victim-survivors of the same cultural background as the worker/elder. The focus is on exploring the cultural meaning of experiences of sexual violence and resultant distress, and also to gain knowledge about the victim-survivor's culture to facilitate engagement (Kirmayer, Guzder, & Jarvis, 2014). Some Aboriginal and Torres Strait Islander communities may prefer a model of **cultural brokerage** rather than cultural consultation.

Cultural safety: The act of fostering a safe and respectful environment which recognises and respects the specific cultural needs of an individual or community. Culturally safe practice recognises that there are power relations in and between all cultural groups and at all levels (Commonwealth of Australia, 2017) and so critically engages with how people's health and safety is influenced by historical, political and socioeconomic contexts. Unsafe cultural practice includes any actions, whether intentional or unintentional, which diminish or demean the cultural identity and wellbeing of an individual (Gerlach, 2012). In an Australian context, this includes support which respects Aboriginal and/or Torres Strait Islander cultural values, strengths and differences, and also addresses racism and inequity (Australian Institute of Health and Welfare, 2021).

Debriefing: A process usually administered to groups of people shortly after a traumatic incident, in which participants identify their thoughts and feelings in response to the incident (Salter et al., 2020).

Defuse: A short process that assists people to identify the impacts of an event on them and the strategies that may assist them to manage it effectively, recommended as an effective strategy for managing the impacts of exposure to traumatic material (Salter et al., 2020).

Domestic and Family Violence: Domestic violence refers to acts of violence that occur between two people who are, or were, in an intimate relationship. It includes a range of behaviours – physical, sexual, emotional, psychological, financial and technology-facilitated abuse, as well as coercive control. While there is no single definition, the behaviour is violent or threatening and the victim-survivor is controlled through fear, coercion and intimidation (Department of Social Services, 2021). Family violence involves the same sorts of behaviours mentioned above, but includes the broader range of marital and kinship relationships in which violence may occur (Department of Social Services, 2021). Most relevantly for this context, sexual violence and coercion can be one of the dynamics of domestic and family violence.

First Nations: A term which recognises the peoples or nations of people who have lived in a particular geographic location from the beginning, prior to the settlement of other peoples or nations. In Australia, this term is increasingly used to acknowledge Aboriginal and Torres Strait Islander peoples as the sovereign people of this land, and equally recognises the various language groups as separate and unique sovereign nations (Common Ground, 2021).

Grooming: Behaviours that manipulate and control a child, their family and other support networks, or institutions with the intent of gaining access to the child, obtaining the child's compliance, maintaining the child's silence, and avoiding discovery of sexual abuse. Grooming can take place in person and online, and is often difficult to identify and define. The behaviours may not be overtly sexual or abusive in themselves, but they are motivated by a desire to gain access to the child for the purposes of sexual abuse. Perpetrators can groom children, other people in children's lives, and institutions (Royal Commission into Institutional Responses to Child Sexual Abuse, 2017b).

Grooming is a where an adult communicates, by words or conduct, with a child under the age of 16 years with the intention of facilitating the child's involvement in sexual conduct. It is often a gradual process and can be conducted in person or online. Frequently, the families or carers of children are groomed in order to enable access to the child, and they should also be considered victims. Grooming is a stand-alone criminal offence in some states and territories, and at the federal level.

Harmful sexual behaviour: This term is used to refer to children under 18 years of age who have behaviours that fall across a spectrum of sexual behaviour problems, including those that are problematic in terms of the child's own development, and/or are coercive, sexually aggressive or predatory towards others (Royal Commission into Institutional Responses to Child Sexual Abuse, 2017b).

Image-based sexual abuse: Image-based sexual abuse is defined as the non-consensual taking, sharing or threats to share nude or sexual images (photos or videos) of a person (Powell, Scott, Flynn, & Henry, 2020).

Incest: Also known as intra-familial child sexual abuse, incest is understood by specialist sexual violence services as the crime of sexually abusing a child that is closely related to you (Lawson, 2018).

Institutional child sexual abuse: Broadly speaking, this form of child sexual abuse occurs when it happens on the premises of an institution, where activities of an institution take place, or in connection with the activities of an institution, or is committed by an official of an institution in circumstances whereby the institution has in any way contributed to the risk of child sexual abuse occurring (Royal Commission into Institutional Responses to Child Sexual Abuse, 2017b).

Integration: Formal and informal integration, coordination and collaboration can take many forms, and can be understood as a continuum, with integration the end point, where services are delivered by a single system with sub-units and cross-unit accountability (Wilcox, 2010, cited in NSW Government, 2020).

Interagency practice: Refers to occasions where specialist sexual violence services must work with one or more external agencies to meet the needs of a victim-survivor.

Intergenerational trauma: The transmission of traumatic symptoms and vulnerabilities from parent to child. This may be related to culture-wide changes and social fragmentation, parenting and attachment styles and/or potential epigenetic transmission (Salter et al., 2020). The term intergenerational/historical trauma was initially developed by First Nations and Aboriginal peoples in Canada, and in Australia, intergenerational trauma is most evident in Aboriginal and Torres Strait Islander communities living with the legacy of colonisation.

Intersectionality: Taking an approach that considers the complexity of a person's identity and how that manifests in their lived experience, and simultaneously considering how systemic forms of violence and discrimination can interact with one another, creating multiple barriers for individuals (Domestic Violence Resource Centre Victoria, 2018).

Interventions: Professional activities undertaken by clinicians in a clinical setting, directed at assessing, maintaining or improving the health and wellbeing of a person (Australian Institute of Health and Welfare, n.d.).

Intimate Partner Sexual Violence: Any form of sexual violence inflicted on a person by their intimate partner, or former sexual partner. Such sexual violence can take the form of sexual assault/rape, but other more subtle behaviours are also captured by this term, such as the use of coercion, threats, or blackmail to obtain sexual acts (Tarzia, 2020). There may be pressure to perform sexual acts that a person is not comfortable with, that they find degrading, or that are painful (Backhouse & Toivonen, 2018). IPSV can include image-based abuse or the forced consumption of pornography (Australia's National Research Organisation for Women's Safety, 2019). Furthermore, reproductive coercion may be a feature of relationships in which IPSV is present.

People with disability: People with disability have long term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others (UN General Assembly, 2006).

Problematic sexual behaviours: Refers to behaviours that fall outside the normal or age appropriate range for younger children. These may or may not result in harm to another person. Problematic sexual behaviours in young children may be an indicator that they have been harmed and may place the child displaying the behaviours at risk of sexual exploitation (Royal Commission into Institutional Responses to Child Sexual Abuse, 2017b).

Reproductive coercion: Behaviour that interferes with the autonomy of a person to make decisions about their reproductive health. It includes any behaviour that has the intention of controlling or constraining another person's reproductive health decision-making, and can take a variety of forms (Marie Stopes Australia, 2020).

Restorative justice: This is defined as 'any process in which the victim, the offender and/or any other individuals or community members affected by a crime actively participate together in the resolution of matters arising from the crime, often with the help of a fair and impartial third party' (United Nations 2002, Basic Principles on the Use of Restorative Justice Programmes in Criminal Matters Article 1 (3)).

Sexual assault: An act of a sexual nature carried out against a person's will through the use of physical force, intimidation or coercion and includes any attempts to do this. This includes rape, attempted rape, aggravated sexual assault (assault with a weapon), indecent assault, penetration by objects, forced sexual activity that did not end in penetration and attempts to force a person into sexual activity (Australian Bureau of Statistics, 2017). For many victim-survivors of sexual assault the effects can be wide-ranging and lifelong, including but not limited to physical injury and ongoing difficulties with mental health and relationships.

Sexually abusive behaviour: A term applied to children and young people aged 10 to less than 17 years old, that is, the cohort still defined by the criminal law to be minors but who have

reached the minimum age of criminal responsibility (El-Murr, 2017).

Sexual harassment: Sexual harassment is any unwanted or unwelcome sexual behaviour, where a reasonable person would have anticipated the possibility that the person harassed would feel intimidated, humiliated or offended (Australian Human Rights Commission, 2020a).

Sexual violence: In the ABS Personal Safety Survey (2016), sexual violence is defined as the occurrence, attempt or threat of sexual assault since the age of 15 (Australian Bureau of Statistics, 2017). However, many researchers and clinicians in the field conceptualise sexual violence more broadly to encompass child sexual assault, sexual harassment, street based sexual harassment and image-based abuse.

Sibling sexual abuse: Coercive sexual contact between biological, half-, step- and adopted siblings that is not age appropriate and not motivated by developmentally appropriate curiosity. It may consist of a single incident or abuse may have occurred many times (Wong et al., 2020).

Siloing: Is a term used in healthcare to describe a situation where organisations work in isolation and are focused on discrete areas of knowledge, expertise and activity (Maddocks, 2016). Service systems become fragmented and incapable of linking with other organisations that should be related and connected. Information, knowledge and skills are sequestered within each system or subsystem.

Street-based sexual harassment: Unwelcome and uninvited comments, gestures and actions that occur in public and are directed at a person because of their gender, sex, sexual orientation or gender expression. Street-based sexual harassment can take many forms such as whistling, leering, persistent requests for someone's name, number or destination after they've said no, sexual names, comments and demands, verbal abuse, following, flashing, public masturbation, groping, physical and sexual assault (Plan International Australia, 2018).

Technology facilitated abuse: Technology-facilitated abuse is any behaviour that uses technology to harass, monitor, stalk, impersonate or make threats in order to control, frighten or humiliate someone (eSafety Commissioner, n.d.). Technology facilitated abuse is often a feature of domestic and family violence.

Trauma: Individual trauma results from an event, series of events or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional or spiritual wellbeing (Substance Abuse and Mental Health Services Administration, 2014). A person may experience a single incident of trauma, such as witnessing a car accident, or they may be exposed to multiple incidents or multiple forms of trauma. See also **complex trauma**.

Trauma-informed care: It seeks to create safety for survivors by understanding the effect of trauma and its close links with health and behaviour (Quadara, 2015). Trauma-informed care and practice recognises the prevalence of trauma and its impacts on emotional, psychological and social wellbeing of people and communities (Commonwealth of Australia, 2019). The frameworks and strategies of trauma-informed care are relevant to a broad range of human service delivery organisations, not only trauma specialists, as they facilitate understanding, recognition and appropriate responses to the effects of trauma on client engagement and behaviour (Royal Commission into Institutional Responses to Child Sexual Abuse, 2017b).

Trauma specialist: The term “trauma specialist” refers to services or practitioners that have specialist skills in the provision of services designed to address the impacts and effects of trauma and assist them to recover. While many agencies are required to be trauma-informed (i.e., operate with an awareness of the impacts and effects of trauma), trauma specialists are both trauma-informed and deliver trauma-specific interventions or therapeutic treatments (Royal Commission into Institutional Responses to Child Sexual Abuse, 2017b).

Trigger: A stimulus that activates the stress response. People with trauma histories may be left in a state of “high alert” for danger, constantly perceiving threats and danger in the environment when they encounter stimuli that remind them of past trauma. Different people have different triggers; triggers can range from emotional states to smells, touch, songs, places (Blue Knot Foundation, 2020). Media coverage of incidents of sexual or gendered violence can be triggering for victim-survivors.

Vicarious trauma: Transformations to a person’s cognitions as a result of exposure to traumatic material, and experiencing symptoms of secondary traumatic stress such as nervous system dysregulation, avoidance and intrusive thoughts (Salter et al., 2020).

Abbreviations

AAC	Augmentative and Alternative Communication
AHPRA	Australian Health Practitioner Regulation Agency
APPs	Australian Privacy Principles
CEDAW	Convention on the Elimination of all forms of Discrimination Against Women
COAG	Council of Australian Governments
CRC	Convention on the Rights of the Child
CSA	Child Sexual Abuse
DFV	Domestic and Family Violence
IPSV	Intimate Partner Sexual Violence
NASASV	National Association of Services Against Sexual Violence
PHSB	Problematic or Harmful Sexual Behaviour
TIC	Trauma-Informed Care
UN	United Nations

1. Background and Context

1.1. About these Standards

In 2020 the Commonwealth Department of Social Services engaged National Association of Services Against Sexual Violence (NASASV) to develop a third edition of the Standards of Practice Manual for Services Against Sexual Violence. The Gendered Violence Research Network (GVRN), at the University of New South Wales, Sydney (UNSW, Sydney) was subcontracted to work with NASASV to develop the Standards. This third edition updates the second which was produced by NASASV in 2015.

To ensure the evidence base for this revision was of the highest quality, the GVRN undertook a literature review to locate national and international standards, guidelines and research produced over the five years since the previous edition was released. Relevant findings from the literature review were incorporated into the third edition.

This third edition of the Standards was reviewed by the NASASV Steering Committee and the Expert Advisory Group and tested through a national consultation process.

1.2. About NASASV

The National Association of Services Against Sexual Violence works to further the shared aims of services for those who have experienced sexual violence, with the ultimate goal of eliminating sexual violence in the community.

The objectives of NASASV are set out in the Constitution:

1. To co-ordinate the sharing of information, skills and resources between services and state networks on all aspects of service provision and co-ordination. To assist governments in developing policies for building safer communities.
2. To lobby and negotiate with Commonwealth, State and Territory governments, government departments and other relevant organisations on issues of common concern to sexual assault service providers and those who are affected by sexual violence.
3. To promote an understanding of sexual violence in the context of gender and power relations.

4. To promote equity of access to services for all survivors of sexual violence, recognising that women and children are the most predominant survivors of such violence, paying particular attention to those most marginalised on the basis of their race, culture, gender, disability, age, language, sexual orientation and geographic location.
5. To promote community awareness of sexual violence and its personal and social consequences at a state, national and international level and to support and facilitate the community education and community development role of services at a local level.
6. To undertake research relating to service provision for survivors of sexual violence.
7. To provide information on training developments and resources to services and to promote high quality training and skills development for workers through liaison with relevant national and state training bodies and participation in the development of accredited training.
8. To monitor the range and diversity of service models and promote, through the development of best practice models, the best possible services for survivors.
9. To organise and facilitate national meetings, conferences and seminars.
10. To undertake any other activities necessary to fulfil the purpose of the organisation (National Association of Services Against Sexual Violence, 2003).



NASASV is an association of specialist sexual violence services. Victim-survivors of sexual assault and other forms of sexual violence are the clients served by these organisations. Practitioners in these organisations have expertise in supporting people affected by sexual assault, but also possess skills in assisting clients affected by a range of other difficulties related to their experiences of sexual violence or other trauma. Specialist sexual violence services are a type of trauma-specialist service. Please see sections 2 and 3, where these points are addressed in more depth.

1.3. About sexual violence

In the 2016 Australian Personal Safety Survey (PSS) conducted by the Australian Bureau of Statistics (ABS), **sexual violence** is defined as the occurrence, attempt or threat of sexual assault experienced by a person since the age of 15. There are two components of sexual violence in the PSS definition:

Sexual assault: an act of a sexual nature carried out against a person's will through the use of physical force, intimidation or coercion, including any attempts to do this. This includes rape, attempted rape, aggravated sexual assault (assault with a weapon), indecent assault, penetration by objects, forced sexual activity that did not end in penetration and attempts to force a person into sexual activity. Incidents so defined would be an offence under state and territory criminal law.

Sexual threat: the threat of acts of a sexual nature that were made face-to-face where the person believed it was able to and likely to be carried out (ABS, 2017).

Sexual violence is gendered, as statistics indicate that women and girls experience higher rates of sexual violence. The PSS indicated that 1 in 5 women and 1 in 20 men had been affected by sexual violence since the age of 15 (Australian Bureau of Statistics, 2017). However sexual violence can be experienced by and perpetrated by people of all genders (Australian Institute of Health and Welfare, 2020b).

Sexual violence can be experienced at any life stage, and is perpetrated in different spaces – households, institutions, public spaces, politics and online (United Nations Development Programme, 2019). Victims belong to all socioeconomic groups and all cultural and religious backgrounds, but research indicates that some groups are disproportionately affected by sexual

violence in Australian society. The Australian Institute of Health and Welfare (2020b) identifies four primary groups that national data indicates are more likely to be sexually assaulted, including people who:

- are homeless,
- have a disability,
- identify as lesbian, gay, bisexual, trans and gender diverse, or have intersex variations, or
- have previously been sexually assaulted at another stage in their lives.

The authors also note that Aboriginal and Torres Strait Islander peoples, and women from some culturally and linguistically diverse communities, may also be more likely to be sexually assaulted than the general population, but reliable national prevalence estimates are not available. Sex workers also experience higher rates of sexual assault in Australia (Cox, 2015). Older people in nursing homes are noted to be a vulnerable population due to their dependency on caregivers, multi-faceted health problems, and living in close proximity to other residents (Smith et al., 2019). In its final report, the Aged Care Royal Commission commented that the estimated high rates of unlawful sexual contact of residents of aged care are a disgrace (Royal Commission into Aged Care Quality and Safety, 2021).

Sometimes a victim-survivor is targeted due to some aspect of their identity; for example, racially motivated sexual violence, and sexual violence directed towards individuals because of their perceived gender diversity or sexuality. Women with disabilities experience unique forms of sexual and reproductive violence, including forced contraception and forced sterilisation.

Contrary to narratives that continue to be influential in Australian society, most sexual assaults are perpetrated by someone known to the victim (Australian Institute of Health and Welfare, 2020b). In the PSS,

women reported that the most common location of the most recent incident of sexual assault by a male was in the woman's home (Australian Bureau of Statistics, 2017). A growing area of research is intimate partner sexual violence, and the unique and profound physical and mental health impacts of sexual violence in the context of domestic and family violence (Potter, Morris, Hegarty, Garcí'a-Moreno, & Feder, 2020; Tarzia, 2020).

Whilst sexual offences against children were not part of the definition of sexual violence for the PSS, **child sexual assault** is a significant issue in Australia. The definitions of child sexual assault vary across jurisdictions in Australia, but child sexual assault is generally understood to describe incidents where a person has engaged in sexual activity with a child or young person, where there has been physical contact. In most jurisdictions in Australia, a child or young person cannot consent to sex if they are under 16 years of age (in South Australia and Tasmania, the age of consent is 17 years) (Child Family Community Australia, 2021). It remains difficult to ascertain accurate rates of child sexual assault, but in 2018, police recorded around 7,900 sexual assaults against children aged 0-14, which equates to a rate higher than for people aged 15 years and over (Australian Institute of Health and Welfare, 2020b). Girls were 3.5 times more likely to be the victims of police recorded sexual assaults against children than boys (Australian Institute of Health and Welfare, 2020b).

Child sexual abuse is a broader term that encompasses a range of sexual behaviours, not only incidents that have involved sexual contact with a child. It includes "any sexual activity beyond the understanding of the child or contrary to accepted community

standards" (Australian Institute of Health and Welfare, 2020b, p. 11). For example, forcing a child to watch or hear sexual acts, taking sexualised photos of a child, and sexually explicit talk, are all forms of sexual abuse. People who engage in child sexual abuse usually groom children and their families/carers, which can be harmful in itself. The production of **child sexual abuse material**, meaning sexually abusive images of children typically disseminated via the internet (Brown and Bricknell, 2018, in Salter et al., 2021), can constitute child sexual abuse or child sexual assault, depending upon the circumstances. People who engage in child sexual abuse usually groom children and their families/carers, which can cause psychological harm as well as disruption to family dynamics.

The Commonwealth Government's Royal Commission into Institutional Responses to Child Sexual Abuse released its [Final Report](#) in December 2017. The Commission found that **institutional child sexual abuse** has been occurring in Australia for generations. Over 8000 personal stories were shared in private sessions and over 1000 written accounts were provided by adult victim-survivors. Many victim-survivors of institutional child sexual abuse have sought support and counselling from specialist sexual violence services, to address the profound impacts of childhood sexual abuse, and this group of victim-survivors is likely to continue to request services from specialist sexual violence services for many years to come.

Organised sexual abuse of children occurs in contexts other than institutions – in cults, paedophile rings and exploitative family networks. Disclosures relating to sexual abuse in these contexts often involve torture, mind control and physical restraint (Salter, 2018). Research suggests that there

is a strong connection between organised sexual abuse and the production of child sexual abuse material (Canadian Center for Child Protection, 2017, in Salter, 2018).

Broadening out from the definition of sexual violence in the PSS, sexual harassment is also commonly understood as a form of sexual violence.

Sexual harassment is any unwanted or unwelcome sexual behaviour, where a reasonable person would have anticipated the possibility that the person harassed would feel intimidated, humiliated or offended (Australian Human Rights Commission, 2020a). In the context of certain activities and relationships, sexual harassment is unlawful under anti-discrimination legislation.

Where the unwelcome behaviour consists of stalking or intimidation or involves sexual touch without consent that behaviour may amount to a crime.

The PSS collected information about men's and women's experiences of selected types of sexual harassment by male and female perpetrators and found that 1 in 2 women over the age of 18 had experienced sexual harassment in their lifetime, and 1 in 4 men over the age of 18 had experienced sexual harassment in their lifetime. Women were more likely to be sexually harassed than men, and men were equally likely to have been sexually harassed by a male or female. Inappropriate comments and unwanted touching were common for both men and women who reported sexual harassment (Australian Bureau of Statistics, 2017).

The final report of the Australian Human Rights Commission's National Inquiry into **Sexual Harassment in Australian Workplaces**

was released in 2020. Recommendation 55 of the Report states that psychosocial support should be provided to people affected by workplace sexual harassment through a national network of services, including specialist sexual assault services. The Report also noted that these services would need to be funded adequately to ensure that they were accessible and had capacity to accept referrals related to incidents of sexual harassment (Australian Human Rights Commission, 2020b).

In 2017, the Australian Human Rights Commission released "Change the Course: National report on sexual assault and sexual harassment at Australian universities", its report following the first ever national prevalence survey on the number of **university students impacted by sexual violence**. The results of the survey indicated that a significant number of university students have been impacted by sexual assault and sexual harassment. The report noted that the culture of Universities and residential colleges are sites of risk for sexual assault and sexual harassment, and require specific and targeted institutional responses (Australian Human Rights Commission, 2017).

Street-based sexual harassment has typically been endured silently, viewed as part of normal experience, particularly for young women, and not taken seriously (Plan International Australia, 2018). While some countries have criminalised street-based sexual harassment, most forms of street based sexual harassment are not illegal in Australia however there is increasing recognition of the impact that street-based sexual harassment has on routines, enjoyment of public spaces and mental health. Street-based harassment can leave people feeling afraid, powerless and even

at fault (Plan International Australia, 2018), and can be extremely triggering for victim-survivors of sexual violence.

Technology facilitated abuse involves the use of technology to stalk, harass, intimidate, threaten, coerce, monitor and humiliate others, and is often seen in relationships characterised by domestic and family violence. **Image-based sexual abuse** is a form of technology facilitated abuse and is widespread in the community, with a recent international study finding that 1 in 3 respondents had experienced at least one form of image-based sexual abuse victimisation (Powell et al., 2020). Surveys have indicated that a majority of victims of image-based abuse experience high levels of psychological distress, consistent with a diagnosis of moderate to severe depression and/or anxiety disorder (Henry, Powell, & Flynn, 2017). Given that people who perpetrate image-based abuse are typically known to the victim (Henry et al., 2017), there may be psychological impacts relating to the betrayal of their trust, which sexual violence services are experienced in addressing. The non-consensual distribution of intimate images, or threats to do so, has been criminalised in most States and territories in Australia, and a civil penalties scheme exists at the federal level (eSafety Commissioner, 2021). While the term “revenge porn” is often used in the media, this term is not used by academics in the field nor by workers in the sexual violence sector, as it fails to capture the diverse motivations behind offending and conflates the non-consensual creation or distribution of intimate images with a sub-genre of legal, commercial photography (Henry et al., 2017).

These Standards provide an overview of current meanings attributed to sexual

violence and refer to these definitions throughout. It is noteworthy that many pervasive societal misconceptions about sexual violence persist in our community. These misconceptions may contribute to prevalence, under-reporting of sexual crimes and high rates of attrition in the criminal justice system (Tidmarsh & Hamilton, 2020).

The National Community Attitudes towards Violence against Women Survey 2017 (NCAS) is a resource for anyone wanting to understand community attitudes and prevent the serious and prevalent problem of violence against women, some of which relate directly to sexual violence. The NCAS shows that whilst the majority of Australians reject attitudes supportive of violence against women, some attitudes remain that negatively influence Australian society’s response to sexual violence and fuel the sense of shame, self-blame and stigma that victim-survivors often experience. These include:

- The belief that women make false allegations of sexual assault when evidence shows that false reporting of sexual assault is rare.
- That 1 in 3 Australians are unaware that a woman is more likely to be sexually assaulted by someone she knows, than by a stranger (Webster et al., 2018).
- High levels of community mistrust in women’s reports of sexual assault victimisation in some contexts.
- Beliefs that coerced sex in marriage is legal when it is illegal.

Other forms of sexual violence that are not as prevalent in Australia, but may have been experienced by victim-survivors that have arrived from other countries include **systematic rape** as part of armed conflict, **sexual slavery**, and **honour-based violence**,

such as female genital mutilation, forced marriage and wife inheritance (World Health Organization, 2012).

The serious and multifaceted consequences for victim-survivors that flow from sexual violence are well established, and include:

- short- and long-term consequences on physical, mental and sexual health,
- negative impacts on the health and wellbeing of the children of victim-survivors,
- economic hardship and decreased job satisfaction and confidence,
- transmission of disadvantage across generations,
- decreased participation in economic, social and civic activity, and
- increased costs to employers and the Australian economy (Webster et al., 2018).

Additional analysis of the PSS data relating to childhood abuse (physical and sexual) found that a proportion of respondents had experienced multiple forms and incidents of abuse or violence (Australian Bureau of Statistics, 2019). Adults can also be impacted by multiple incidents of violence, and different forms of abuse (such as in situations of DFV). Indeed, single abusive incidents are increasingly being recognised as the exception rather than the norm (NSW Ministry of Health, 2019a). The health and wellbeing consequences experienced may be cumulatively and incrementally worse for victim-survivors who have been affected by multiple episodes or forms of abuse (NSW Ministry of Health, 2019a). Specialist sexual violence services have long serviced this group of victim-survivors with complex histories of sexual violence and other experiences of trauma.

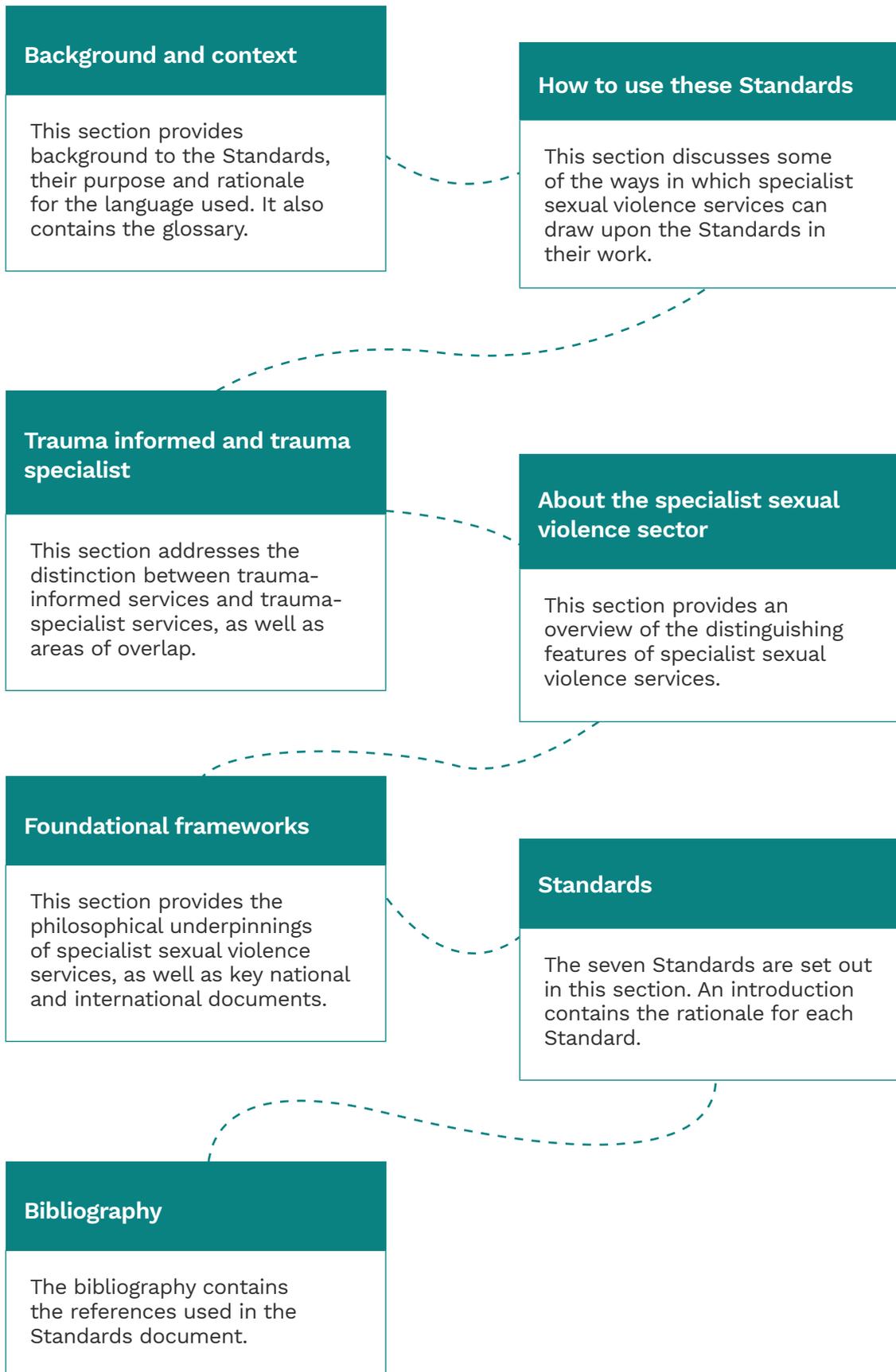
1.4. The purpose of these Standards

The purpose of these Standards is to ensure accessible, high quality and consistent service provision to clients of NASASV member organisations in Australia. The Standards will:

- articulate the standards of practice to be delivered by organisations, as well as practitioners within those services.
- allow government, relevant agencies and the wider community to better understand the work of member organisations, as well as their philosophical underpinnings.
- provide guidance for member organisations and practitioners employed within these services. Member organisations should translate these standards to their particular service context, and ensure that their service model, operating procedures and clinical practice align with the Standards.

This edition of the Standards expands upon the previous edition by including guidance on providing services to children and young people who have experienced child sexual abuse, and children and young people exhibiting harmful sexual behaviours – client groups not addressed in the previous edition.

1.5. Structure of the Standards



1.6. How to use these Standards

These Standards provide an up-to-date guide for services to ensure high-quality and consistent service provision and in doing so articulate the specialist nature of the work delivered by sexual violence services. Member organisations and their staff can use the Standards:

- as a **quality improvement tool**, by evidencing their progress against the Standards, identifying areas for improvement and then making action plans to address any gaps.
- as a **tool for staff supervision** and to encourage critical reflection.
- as a guide **to orient new staff or students** to both the sector and their role within the organisation.
- to offer to clients to **evidence transparency** within the service.
- to provide **partner agencies** with a strong understanding of how member organisations work and to identify how the agencies can best work together.
- to **share with practitioners from other services** who support mutual clients, so that professionals working with the client can better understand the role and philosophy of the sexual assault service.
- **as part of tendering processes** to reflect the specialist, complex and diverse work of member organisations and to differentiate member organisations from more generalist services in the community that may be competing for work.
- as part of **funding negotiation** to advocate for some essential components of a specialist sexual violence services' budget, such as staff supervision, ongoing professional development, and time needed to collaborate with other agencies regarding complex clients. While these tasks may not be understood as direct service provision, they are an essential part of the capacity building in the sexual violence sector and ensuring high-quality service provision.

1.7. Language used in these Standards

Choices regarding language in the field of sexual violence are always contested, and preferences around terms used have changed over time, reflecting various priorities. We recognise that organisations may have particular preferences around the terminology they employ for a range of reasons, and clients of sexual violence services may also have views. Terms that resonate with some individuals will be alienating for others. Organisations will need to regularly revisit the language that they use, to see whether the terms continue to work well for their clients and reflect their experiences.

We have chosen to use the term 'victim-survivor' to refer to people who have been subjected to sexual assault or child sexual abuse. This term is preferred by many in the field as it reflects the criminality of acts of sexual assault (victim), but also the strength, courage and resilience demonstrated in the aftermath of sexual assault (survivor).

Statistics tell us that sexual assault and child sexual abuse are gendered crimes in Australia and around the world, with women and girls representing the majority of victim-survivors (Australian Bureau of Statistics, 2017). However, men and boys, and people who identify as gender non-binary, are also victims of sexual assault and child sexual abuse. The term 'victim-survivor' allows us to talk about the impacts and effects for all people who have been subjected to sexual assault.

We also know that the majority of adults who perpetrate sexual violence are male (Australian Institute of Health and Welfare, 2020b), although women and people of diverse genders can also perpetrate sexual assault and child sexual abuse. To reflect this, we use the gender-neutral expression 'people who perpetrate sexual violence'. This term is not suitable in relation to children and young people who exhibit harmful

sexual behaviours. For children under 10 years old, we use the term problem sexual behaviours; for young people aged between 10 and 17 years, we use the term sexually abusive behaviour.

In these standards, we have used the term 'Aboriginal and Torres Strait Islander peoples' rather than 'First Nations' peoples. We recognise and respect that both terms are used and recommend that this language be revisited in future editions of the Standards.



2. The Distinction, and Overlap, Between Trauma-Informed Care and Trauma Specialist Services

Definition:

“Trauma-informed care and practice recognises the prevalence of trauma and its impacts on emotional, psychological and social wellbeing of people and communities” (Commonwealth of Australia, 2019, p. 60).

2.1. What does it mean to be trauma-informed?

The concept of trauma-informed care, developed by Harris and Fallot in 2001, has been increasingly embraced by health and human service agencies around the world. The National Plan to Reduce Violence against Women and their Children 2010 – 2022, Fourth Action Plan provides the definition to the left.

It is important to note that being trauma-informed is seen as the end point of a continuum, as represented in the graphic below, adapted from Wall, Higgins, and Hunter (2016):



In the context of sexual violence, trauma-informed services must take a systems-level approach, modifying all aspects of the system that influence the way that care is delivered (NSW Ministry of Health, 2019a). These services must operate according to the key principles of trauma-informed care, which are:

- **Safety** – ensuring physical and emotional safety
- **Choice** – individuals have choice and control
- **Empowerment** – prioritising enablement and skills building
- **Trustworthiness** – task clarity, consistency, interpersonal boundaries
- **Collaboration** – sharing decision making and power (NSW Agency for Clinical Innovation, 2019).

Some models of trauma informed care also highlight the importance of cultural, historical and gender issues being built into a trauma informed response. Organisations and practitioners must actively counter stereotypes and biases, offer gender responsive services, and leverage the healing value of traditional cultural practices. In addition, trauma informed services must recognise and address intergenerational trauma (Substance Abuse and Mental Health Services Administration, 2014).

Whilst the interest in trauma-informed care is encouraging, there is evidence of inconsistent understandings of what it means to be “trauma-informed” (Wall

et al., 2016). Using the graphic above, it is evident that many organisations that claim to be “trauma informed” would more accurately be described as “trauma aware”. Confusion about the concept has led to recommendations for whole-of-government coordination of trauma informed practice across sectors (Salter et al., 2020).

The concept was developed to positively influence the way that human service organisations engage with clients. Applying the lens of trauma informed care encourages organisations and practitioners to consider ‘what has happened to a person’ rather than ‘what is wrong’ with them. Comprehensive implementation of the trauma-informed care would produce a profound cultural shift in human service organisations (Kezelman & Stavropoulos, 2019).

Trauma as a result of sexual violence affects a large proportion of the population, and victim-survivors are clients in a broad range of human services, not only services that specifically address the impacts of trauma (Wall et al., 2016). Organisations that are trauma-informed may be better able to engage clients, avoiding retraumatizing or pathologising them. Research has indicated that trauma-informed care improves client outcomes and is cost effective (Henderson, Everett, & Isobel, 2018; NSW Ministry of Health, 2019a; Quadara & Hunter, 2016).

Trauma-informed care challenges the traditional symptom-based approach of

the medical model and is an alternative approach to the presenting issues, difficulties and ‘problems’ of victim-survivors and has different treatment implications (Kezelman & Stavropoulos, 2019). A trauma-informed approach does not preclude the use of medication to alleviate symptoms, and for some clients of specialist sexual violence services the use of medication alongside counselling will improve their functioning.

2.2. What does it mean to be a trauma specialist service?

Most specialist sexual violence services would be described as trauma-informed AND trauma specialist (NSW Ministry of Health, 2019a). The concept of trauma-informed care did not originate in the sexual violence sector, nevertheless the principles of trauma-informed care resonate with existing good practice in the sector.

Trauma specialist services are designed to “directly treat ‘the actual sequelae’ of traumatic experiences” (Kezelman & Stavropoulos, 2012, p. 89), and facilitate the recovery of victim-survivors. Trauma specialist services assist victim-survivors to develop an understanding of the relationship between their current difficulties and past traumatic experiences (Atkinson, 2013). They support them to find healthy and adaptive ways to deal with trauma symptomatology and improve day-to-day functioning. Treatment plans are decided in consultation with the victim-survivor and depend on their particular needs and circumstances (Atkinson, 2013). Discussing trauma history in depth with a counsellor may or may not form part of the work.

Organisations that offer counselling to traumatised populations in the community, such as victim-survivors of DFV, survivors of child abuse and institutional abuse, refugees, veterans of armed conflict and some child protection counselling services would be regarded as trauma-specialist services.

Some additional features of trauma specialist services include:

- Use of standardised and evidence based assessments of trauma history and symptoms (Johnson, 2017).
- Use of trauma-focused therapeutic interventions, delivered by skilled clinicians (Johnson, 2017).
- Staff possess extensive knowledge of the impact of trauma (NSW Ministry of Health, 2019a).
- Knowledge and skills in teaching emotional regulation techniques (Phoenix Australia, 2020).
- Taking time to develop the counselling relationship when working with clients with interpersonally generated trauma (Kezelman & Stavropoulos, 2012; Phoenix Australia, 2020).

Sexual violence services are trauma specialists, who possess the knowledge and skills to support victim-survivors to recover from the impact of a particular form of interpersonal trauma, sexual violence. Many victim-survivors have experienced other forms of trauma in addition to sexual violence. The knowledge and skills practitioners in specialist sexual assault services have meant that in many cases, they can support clients to process and address these experiences as well. In some complex cases, the client may consent to an integrated model of care, where the practitioner from the sexual assault service works with professionals from other services to ensure the client’s needs are being met.



3. About The Specialist Sexual Violence Sector

3.1. Defining specialist sexual violence services

Although a range of organisations deliver services to victim-survivors of sexual assault or other forms of sexual violence, not all of these services can be regarded as specialist sexual violence services. Whilst there is considerable diversity in the sector, the points below highlight common ground amongst specialist sexual violence services around Australia.

Core business: The core client groups of the service/service stream/program are:

- Adult victim-survivors of recent or historical sexual assault, sexual violence or sexual abuse.
- Adult victim-survivors of childhood sexual assault, sexual violence or sexual abuse.
- Adult victim-survivors of ongoing sexual abuse, in the context of intimate partner sexual violence.
- Children and adolescent victim-survivors of sexual assault, sexual violence or sexual abuse.

- Non—offending family/caregivers and supporters of the above.

Some specialist sexual violence services also provide services to children and young people who exhibit harmful sexual behaviours and their non-offending families/caregivers in addition to their work with victim-survivors. The arrangements for providing services to children and young people who exhibit harmful sexual behaviours varies depending on jurisdictional arrangements and funding. Some specialist sexual violence services only provide a service to children under 10 with problematic sexual behaviours in addition to their core business; others see children and young people up to the age of 18. Some jurisdictions have separate services, aligned with specialist sexual violence services, that see children and young people with harmful sexual behaviours (See for example, Newstreet in NSW, which is funded specifically to provide therapeutic services for children and young people aged 10 to 17 years who have engaged in harmful sexual behaviours towards others, and their families and caregivers).

Specialist service provision: The services provided by a specialist sexual violence service include some or all of the following:

- Crisis counselling
- Short, medium to long term counselling
- Medical and/or forensic services
- Case management
- Integrated practice with other professionals and allied agencies
- Referral
- Group work
- Court preparation and support
- Report preparation for court or compensation.
- Training and community capacity building to respond to disclosure of sexual assault/abuse

These services may also be provided to non-offending family/caregivers and supporters.

Evidence based: All services offered to clients are informed by current evidence and practice wisdom.

Trauma-informed and trauma specialists:

The organisation of the service, and its systems, should reflect the principles of trauma-informed care. All staff (including administrative and reception staff) should have knowledge of trauma-informed care, to ensure that they can facilitate client engagement with the service. Clinical staff (counselling and medical) should undertake additional training in the field of trauma, and commit to ongoing professional development, to acquire and maintain specialist knowledge and skills.

Consultation and training: The service is available to provide consultation on the impacts of sexual violence and abuse and the needs of victim-survivors to other professionals. It may also offer training to these professionals.

Primary prevention: Services initiate and participate in activities designed to drive the change needed to end sexual violence, challenging gender inequality, violence supportive attitudes and social norms.

Community engagement and education:

The service provides community education on the impacts of sexual violence and abuse and attends community events where possible, providing resources about the service and the impacts and effects of sexual assault, sexual violence and sexual abuse.

Advocacy: Staff advocate within broader service systems for the needs of victim-survivors, children and young people who exhibit harmful sexual behaviour and their non-offending families and caregivers.

Funding: The service/service stream/program may be delivered through Health or Justice Departments, or specifically funded by government as a non-government organisation (NGO). Some funding may be provided by philanthropic sources.

3.2. About the client groups who can access specialist sexual violence services, and the services provided

As mentioned in the previous section, there is considerable diversity in the specialist sexual violence service sector in Australia. The graphic below reflects this diversity in showing the range of clients that may be eligible to attend, the range of services that may be offered and the variety of options for service delivery that may be available.

It is important to note that many services also have geographic limits to their service provision, and some may require approval from child protection, police or other agencies before they can conduct medical examinations or commence therapeutic work with children and young people.

Who can access our service?

- a) Adult victim-survivors of recent or historical sexual assault, violence or abuse
- b) Adult victim-survivors of childhood sexual assault, violence or abuse
- c) Children and adolescent victim-survivors of sexual assault or abuse
- d) Children who exhibit harmful sexual behaviours
- e) Adolescents (up to the age of 18) who exhibit harmful sexual behaviours
- f) Non-offending family, caregivers and supports of client groups above

What do we offer?

- a) Referral
- b) Crisis counselling
- c) Short, medium and long term counselling
- d) Therapeutic groups
- e) Forensic services
- f) Medical services
- g) Case management
- h) Community and/or professional education
- i) Systems advocacy
- j) Collaborations-partnerships with other services or professionals
- k) Court preparation and support
- l) Reports for court/compensation

How do we deliver services

- a) Face to face
- b) Online chat
- c) Telephone
- d) Video technology
- e) In partnership with other services.

3.3. Specialist work

Working with victim-survivors of sexual violence is specialist work and often complex. Although victim-survivors may present to a sexual violence service with an account of a discrete incident of sexual assault, there may be more traumatic incidents in their past. Many victim-survivors have experienced multiple forms of abuse, or multiple incidents of abuse, and there is increasing acceptance that a single incident of trauma is the exception rather than the norm (NSW Ministry of Health, 2019a). This is particularly the case for women who have been sexually assaulted in the context of DFV, for adult survivors of child sexual abuse (including those abused in institutions), for those who have been removed from their parents' care and for children and young people who have been sexually abused. As the Royal Commission noted:

“ ...trauma resulting from interpersonal abuse that is prolonged or repeated ... has a different nature and impact than that which is the consequence of an individual traumatic event” (Royal Commission into Institutional Responses to Child Sexual Abuse, 2017b, p. 23)

There is also increased awareness that the health and social consequences of experiencing multiple incidents or forms of abuse are cumulative (NSW Ministry of Health, 2019a). For this reason, victim-survivors may be experiencing a range of physical and mental health difficulties, as well as practical issues. Providing therapeutic and medical support to victim-survivors of sexual violence requires knowledge of a range of associated issues, systems and services, including but not limited to:

- Mental health
- Alcohol and other drugs
- Domestic and family violence
- Sexual health
- Legal systems, particularly criminal and family law
- Child protection
- Relationship issues
- Social security
- Homelessness and housing.

Practitioners need to undertake comprehensive assessments to be able to ascertain trauma history, make safety plans and identify appropriate therapeutic interventions to discuss with the victim-survivor. With the victim-survivors' consent, they may take on an advocacy and/or case management role, identifying required support services, make appropriate referrals, advocate for client needs and collaborate/coordinate with other agencies.

Work with children and young people who have been sexually abused also requires specialist skills. Complexity can stem from family conflict around the needs of the child, relationship breakdown in the family of origin and/or extended family (particularly if the person who perpetrated sexual violence was part of the family system, or the child was sexually harmed by a sibling) and the involvement of child protection or out of home care.

When working with children and young people with harmful sexual behaviours, practitioners require knowledge of the complex drivers of the behaviours in the various age groups, possible legal and child protection responses, and skills in managing the responses of family and caregivers to the behaviour. Practitioners may need case management skills, or advocacy skills, particularly in jurisdictions where treatment options are limited. In cases of sibling sexual abuse, practitioners must navigate complex family dynamics.

The paragraphs above highlight the

specialist knowledge and skills possessed by workers in the sexual violence field. Victim-survivors, particularly adult survivors of child sexual abuse, often present with complex needs. The practitioner requires advanced therapeutic skills as well as strong advocacy skills as they engage with systems around the victim-survivor. As many services offer face to face counselling, groupwork and telephone/online support, practitioners need to possess skills in delivering services through a variety of different mediums.



4. Foundational Frameworks

4.1. Underpinnings

Practitioners in specialist sexual violence services are supported by a shared philosophical understanding of the drivers, impacts and effects of sexual violence, and the best ways to support the recovery of victim-survivors. Key national and international documents also form part of the framework of their practice.

4.2. Feminist understandings of sexual violence

Feminist understandings of sexual violence inform the sector's conceptualisation of the drivers of sexual violence.

Sexual violence is gendered; that is, it disproportionately affects women and girls (Australian Bureau of Statistics, 2017; Council of Australian Governments, 2011). Therefore, a gendered analysis is central to understanding how gender inequalities are an underlying driver for sexual violence. Although there is not one "feminism", feminists of a range of perspectives approach sexual violence perpetrated against women and children as being about

violence and power, rather than being motivated only by sexual gratification. A feminist understanding of sexual violence allows us to recognise the interconnections between all forms of sexual violence and how they work together to maintain and reinforce women's inequality. The diversity of feminist thought, and the achievements of feminist activists are celebrated by many in the sexual violence sector.

Feminist scholars and activists have been arguing for decades that the fear of rape restricts women's freedom of movement and therefore acts as a tool of social control (Vera-Gray, 2016b). Recent work has drawn attention to experiences of everyday sexism, such as street based sexual harassment, which function within the "current structures of gendered power" (Vera-Gray, 2016b, p. 13). Women do a significant amount of "safety work" every day to try to avoid sexual violence, impacting on their use of public space (Vera-Gray, 2016a).

Women with a public profile, such as politicians and journalists, often experience threats of rape and violence, arguably a form of backlash around women's participation in public life (United Nations Development Programme, 2019). Such actions are motivated by a desire to silence women,

make them fearful and prevent them from exercising their freedoms. The digital public space, encompassing social media and online platforms, represents a new site of harassment for women and girls (United Nations Development Programme, 2019).

Feminist understandings of sexual violence that have informed the sector for so long are now endorsed by the Government. In the National Plan, the Australian government explicitly acknowledged that gendered violence and gender inequalities have a profound effect on violence against women and their children (Council of Australian Governments, 2011). The “Change the Story” framework was developed to help the whole Australian community to make the connections between gender inequality and all forms of violence against women (Our Watch, Australia’s National Research Organisation for Women’s Safety, & VicHealth, 2015). The Fourth Action Plan noted “We must address gender inequality to stop violence — women will never be safe if they are not equal” (Commonwealth of Australia, 2019, p. 18).

4.3. Intersectionality

From the 1980’s, criticism of the feminism’s privileging of gender as the primary site of oppression emerged. Pioneered by black feminist activist and academic now Professor Kimberle Crenshaw, who criticised both the feminist movement and the anti-racist movement’s failure to address the experiences of women of colour (Domestic Violence Victoria, 2020), “Intersectionality” is:

“A theoretical approach that understands the interconnected nature of social categorisations – such as gender, sexual orientation, ethnicity, language, religion, class, socioeconomic status, gender identity, ability or age – which create overlapping and interdependent systems of discrimination or disadvantage for either an individual or group” (State of Victoria (Family Safety Victoria), 2018, p. i).

Every individual’s identity, social positions and experiences are shaped not just by gender, but by a range of other social categories of difference (Our Watch, 2017). Relying solely on a gendered analysis of sexual violence prevents recognition of how other forms of oppression intersect with sexism and gender inequality (Domestic Violence Victoria, 2020). The image below is a visual portrayal of intersectionality, as understood by Our Watch, a national leader in the primary prevention of violence against women and their children in Australia.

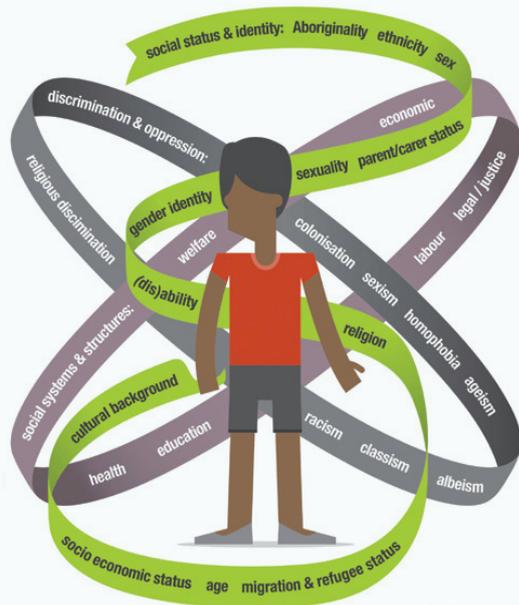


Image: Our Watch

Source: Domestic Violence Resource Centre Victoria (2018)

Just as sexual violence is a gendered crime, it is also a crime that disproportionately affects groups in our society that are socially marginalised. We know that, for example, Aboriginal and Torres Strait Islander women, women with a disability, women who are homeless and people who are sexuality and gender diverse experience sexual violence at higher rates than the general population (Australian Institute of Health and Welfare, 2020b). It is important to note that:

“Many women from diverse groups belong to more than one community and identify themselves in more ways than one” (Mitra-Kahn, Newbigin, & Hardefeldt, 2016, p. 31).

In other words, some women, as well as some men and people of diverse genders, belong to marginalised groups within marginalised groups in Australian society. An intersectional lens provides a fuller understanding of the victim-survivors experience, and helps us recognise connections between that

person’s identity, and the risks, impacts and barriers that the victim-survivor faces (Domestic Violence Victoria, 2020; DVNSW, 2017). It also encourages us to appreciate that each victim-survivor’s story and experiences are unique (DVNSW, 2017). The approach demands that organisations and practitioners recognise the depth of diversity in the communities they serve and actively apply the concept to their systems and clinical work.

The Fourth Action Plan reflects the approach of many organisations in the violence against women space in acknowledging the intersectional drivers that contribute to violence against women (Commonwealth of Australia, 2019). The Plan also undertakes to “respect, listen and respond to the diverse lived experience and knowledge of women and their children affected by violence” (Commonwealth of Australia, 2019, p. 6).

4.4. Trauma model of recovery

The specialist sexual violence sector has long drawn on the seminal work of pioneering American psychiatrist Judith Herman, who, in her book “Trauma and Recovery” (1992), set out three stages of recovery from complex trauma – safety, remembrance and mourning and reconnection with ordinary life. The importance of staged/phased treatment continues to be endorsed by many other organisations and clinicians.

In their 2019 Guidelines, Blue Knot Foundation referred to phased treatment as the “gold standard” for complex trauma treatment (Kezelman & Stavropoulos, 2019). Similarly, Phoenix Australia (2020), in their Australian Guidelines for the Prevention and Treatment of Acute Stress Disorder, Posttraumatic Stress Disorder and Complex PTSD, state that expert opinion favours a phased approach to the treatment of complex PTSD in survivors of sexual assault.

Building on the work of Judith Herman, the three recommended phases of trauma treatment are:

- Phase 1. Safety and stabilisation
- Phase 2. Processing of traumatic memories
- Phase 3. Integration (Kezelman & Stavropoulos, 2019).

The phased approach is based on clinical experience and recognises that many clients with complex trauma histories, including those with severe childhood trauma, often require an initial period in therapy where they work on developing fundamental skills. Self-care strategies, managing symptomatology, improving functioning and establishing some positive self-identity better equip clients for the painful task of processing traumatic memories, and reduces the risk of retraumatisation (Kezelman & Stavropoulos, 2019).

It is important to note that each individual’s response to traumatic events is unique and reflects a complex interplay of factors (Domestic Violence Victoria, 2020). Whilst a phased approach is endorsed, recovery from trauma is not a simple or linear process (Kezelman & Stavropoulos, 2019), with clients often moving in and out of phases. Safety and stabilization may need to be revisited many times.

Shapiro notes that “There is no one perfect trauma therapy” (cited in Kezelman & Stavropoulos, 2019); the treatment landscape in their field of trauma is diverse

and dynamic. Blue Knot advocates that clinicians integrate a range of credible interventions and treatment approaches into the phased treatment model (Kezelman & Stavropoulos, 2019). Similarly, Phoenix Australia suggests that following an initial period of stabilisation, clinicians should use multiple interventions targeting the most prominent CPTSD symptoms (Phoenix Australia, 2020).

The capacity of individuals to engage in recovery from trauma is related to socioeconomic factors and other life stressors. For some individuals and groups facing extreme hardship such as poverty, community violence and homelessness or insecure housing, it may be difficult, impossible or inappropriate to prioritise therapy. In such cases, sexual violence services should seek consent to connect clients with other services that can assist with these pressing needs and offer clinical services again in the future.

4.5. Social justice

Also important is the social justice perspective, which promotes principles of equity and fairness of opportunity and access (Domestic Violence Victoria, 2020). Inclusivity and diversity are recognised as essential, alongside genuine consultation with victim-survivors and communities about their needs. The resources in a society must be fairly distributed to ensure that basic needs can be met and the quality of life of victim-survivors can be improved (DVNSW, 2017). Experiences of sexual violence can be compounded by inequitable systems and services, resulting in continuing disadvantage in areas such as financial security, education outcomes, mental and physical health, and overall social engagement.

4.6. Anti-oppressive practice

Anti-oppressive practice (AOP) is a critically reflective social work practice that seeks to address and challenge social inequality and systemic power imbalances affecting clients. AOP is a dynamic process based on the changing complex patterns of social relations. A definition of AOP must therefore address the multiple and complex factors of contributing to structural inequality at both a systemic and an individual level. While definitions vary, leading AOP scholar Lena Dominelli argues that AOP:

“ ... addresses social divisions and structural inequalities in the work that is done with people whether they be users (‘clients’) or workers. AOP aims to provide more appropriate and sensitive services by responding to people’s needs regardless of their social status.”
(Dominelli, 1996, p. 170)

AOP recognises that acts of violence and abuse are situated within a broader structural and social context and, by doing so, AOP critiques a traditional view that these problems are the fault or responsibility of an individual client. The specialist sexual violence sector in Australia has long embraced AOP in the provision of support by engaging with person-centred and strengths-based approaches.

Services that use AOP must acknowledge the use and abuse of power on individual, organisational and systemic levels which may be overtly, covertly or indirectly discriminatory. This means working in a way that actively disrupts the biases, beliefs and structures that perpetuate power imbalances and may further victimise people with lived experience. Therefore,

AOP requires organisations and service providers to be self-reflective, examining their own biases and their own role in perpetuating systemic power imbalances. In adopting an AOP approach, services challenge inequalities and stand against injustice whilst simultaneously recognising the strength and capability of clients as agents in their own lives (Domestic Violence Victoria, 2020).

4.7. Victims’ rights

In all States and Territories in Australia, the rights of victims of crime are protected in various Charters and declarations. Although there is considerable diversity amongst definitions and the schemes provided by these instruments, some principles have been identified as consistent across jurisdictions:

- The right to respectful and dignified treatment – victims of crime should be treated with dignity and respect and provided with support that is responsive to their needs. Practitioners must recognise and value diversity amongst victims of crime.
- The right to information and access – timely referral and information on the range of support services should be offered to all victims of crime.
- The right to justice and fair treatment – victims of crime should be supported in understanding and exercising rights enshrined in the relevant instrument/s in their jurisdiction as they apply to them.
- The right to financial assistance – a person who has been injured by a crime should have access to financial assistance as set out in the relevant instrument/s for the jurisdiction in which the crime was committed, regardless of where they normally reside (Commonwealth of Australia, 2014).

Practitioners in the sector respect the rights of victims of sexual violence, and their practice aligns with the guiding instrument for their jurisdiction.

4.8. Person-centred care

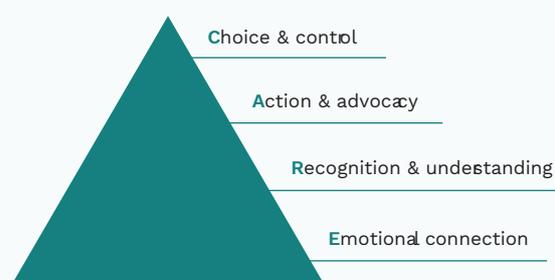
Person-centred care is increasingly recognised as a foundation to safe, high-quality healthcare. It can be described as “...care that is respectful of, and responsive to, the preferences, needs and values” of the individual (Australian Commission on Safety and Quality in Health Care, 2011, p. 1). The approach dictates that clients are equal partners in planning, developing and monitoring care to ensure it meets their needs (Commonwealth of Australia, 2017). People are put at the centre of decision making and professionals work alongside them to get the best outcomes (Health Innovation Network South London, 2014).

Specialist sexual violence services have long delivered services in accordance with the principles of person-centred care. An organisation that delivers person-centred care:

- prioritises the safety of the client and any children
- takes into account the perspectives of clients
- treats clients with dignity and respect
- fosters a safe, supportive and non-judgmental environment
- listens carefully to clients and their histories of violence and abuse, but does not pressure them to talk
- responds to the needs of clients flexibly and holistically
- provides clients with information and supports them to make informed choices and decisions

- ensures confidentiality (within limits) of both the consultation and any records
- provides an immediate response, and provides as much care as possible in the initial contact
- empowers clients to participate in their own care
- is adaptable in terms of the services it provides to the client across their life course (NSW Ministry of Health, 2019a; UN Women: Virtual Knowledge Centre to End Violence against Women and Girls, 2019; World Health Organization, 2013, 2017).

A qualitative meta-synthesis exploring the experiences and expectations of women victim-survivors of intimate partner violence following disclosure to a health care provider was released in 2020 (Tarzia et al., 2020). Based on their findings, the authors developed a model of care (set out below) which has obvious parallels to work in the sexual assault field.



Source: Tarzia et al. (2020, p. 20)

They found that what women valued was:

C- Choice and control. Health care providers must offer options, encouragement and support rather than trying to “fix” the problem.

A – Action and advocacy. Women wanted health care providers to do more than just listen; to provide practical support and/or advocacy in situations in which they were vulnerable.

R – Recognition and understanding. Women valued health care providers who recognised, validated and understood abuse.

E – Emotional connection. Kindness and care were central to women’s expectations of health care providers after disclosure of experiences of intimate partner violence, and they valued ongoing, sustained engagement with their provider.

4.9. Responsibility and accountability for adults who choose to perpetrate sexual violence

In the context of sexual violence, vulnerability can be confused with responsibility. Many victim-survivors of sexual violence have been vulnerable at the time that the sexual violence occurred, and these vulnerabilities have been exploited by the person who perpetrated the sexual violence. Vulnerabilities may include age, disability, being affected by drugs or alcohol, location, or being subject to other forms of childhood adversity. Being vulnerable is not the same as being responsible (NSW Government, 2020). The position of specialist sexual violence services is that victim-survivors of sexual assault are never responsible. Adults who choose to perpetrate sexual violence are responsible for their actions.

The meaning of accountability for those who choose to perpetrate sexual violence varies depending on the context. When specialist sexual violence services talk about accountability for people who choose to perpetrate sexual violence, they are not only talking about criminal sanctions, restricted access to children or requirements to access treatment. Accountability for those who perpetrate sexual violence means locating responsibility for sexual violence with those who perpetrate sexual violence at all times. Practitioners therefore resist invitations to shift responsibility for incidents of sexual assault to victims based upon their vulnerabilities or choices they made. Services actively address shame and reiterate the human rights of all people to live lives free from violence. In some circumstances this may mean advocating for other services, such as police, courts, child protection services and corrections to lift the burden of managing risk from the victim-survivor, or their caregivers, and hold the adults who have chosen to perpetrate sexual violence accountable for their actions.

4.10. Key national documents

The **National Plan to Reduce Violence against Women and their Children 2009-2022** was endorsed by the Council of Australian Governments (COAG) and released in 2011. The National Plan recognises that violence against women and children is a complex issue that requires significant effort and investment from governments (Commonwealth of Australia, 2019). The National Plan is being delivered through a series of three-year action plans. Responding to sexual violence and sexual

harassment was identified as one of five National Priorities for the first time in the Fourth Action Plan, released in 2019. The Fourth Action Plan indicates that states and territories need to

“Deliver client-centred, trauma-informed, specialised and consistent support to victims and survivors of sexual violence” (Commonwealth of Australia, 2019, p. 6).

The Fourth Action Plan also notes the importance of prevention of sexual violence and sexual harassment and strengthening the capacity of all sectors to address sexual harassment. It highlights the importance of responding to the complex needs of Aboriginal and Torres Strait Islander women, listening to the diverse lived experience of women affected by multiple forms of discrimination and inequality, and the importance of collaboration across services, sectors and workforces to support women and children affected by sexual violence (Commonwealth of Australia, 2019). As the current National Plan will cease in 2022, a new National Plan is being developed to commence from 1 July 2022.

In 2017, the Royal Commission into Institutional Responses to Child Sexual Abuse handed down its final report. Volume 9 addressed the advocacy, support and therapeutic treatment service needs of victim-survivors. The report notes that while the recommendations identify essential responses for survivors of institutional child sexual abuse, many of the recommendations are applicable to all survivors of sexual abuse (Royal Commission into Institutional Responses to Child Sexual Abuse, 2017b).

The Report noted that institutional child sexual abuse can have profound, long-lasting, and cumulative impacts on victims and survivors, and that many survivors face a complex set of challenges throughout their lives. They may need to access mainstream and specialist services, and may

need advocacy, support, and therapeutic treatment services at different stages. The report stated that service systems in Australia do not currently have the capacity to meet victim-survivors' needs. Recommendation 9.6 related to enhancing the capacity of specialist sexual assault services:

“The Australian Government and state and territory governments should address existing specialist sexual assault service gaps by increasing funding for adult and child sexual assault services in each jurisdiction, to provide advocacy and support and specialist therapeutic treatment for victims and survivors, particularly victims and survivors of institutional child sexual abuse. Funding agreements should require and enable services to:

- be trauma-informed and have an understanding of institutional child sexual abuse
- be collaborative, available, accessible, acceptable and high quality
- use collaborative community development approaches
- provide staff with supervision and professional development”

(Royal Commission into Institutional Responses to Child Sexual Abuse, 2017b, p. 16).

Volume 10 of the Final Report of the Royal Commission focused on Children with harmful sexual behaviours, and noted the “significant inconsistencies and gaps in Australia’s approach to harmful sexual behaviours in children” (Royal Commission into Institutional Responses to Child Sexual Abuse, 2017a, p. 11). The recommendations included that the Commonwealth, state and territory governments should:

- ensure timely expert assessment for children and young people with harmful sexual behaviours (Recommendation 10.2)
- adequately fund therapeutic interventions to meet the needs of all children and young people with harmful sexual behaviours, provided through a network of specialist and generalist

therapeutic services, with specialist services being resourced to provide expert guidance to generalist services (Recommendation 10.3)

- ensure there are clear referral pathways for children and young people with harmful sexual behaviours (Recommendation 10.4)
- ensure that all services funded to provide therapeutic intervention for children and young people with harmful sexual behaviours provide both professional training and clinical supervision for their staff (Recommendation 10.6)
- fund and support evaluation of services providing therapeutic interventions to children and young people with harmful sexual behaviours (Recommendation 10.7).

Recommendation 10.5 sets out nine principles that should guide therapeutic interventions for children and young people with harmful sexual behaviours (Royal Commission into Institutional Responses to Child Sexual Abuse, 2017a).

Another document relevant to these Standards is the **National Framework for Protecting Australia's Children 2009-2020**, also produced by COAG (Council of Australian Governments, 2009). This Framework sets out an ambitious long term plan to promote and enhance the safety and wellbeing of Australia's children (Australian Institute of Health and Welfare, 2020a). Two of the supporting outcomes of the Framework are relevant to children and adolescents who have experienced child sexual abuse:

- Supporting Outcome 4 "Children who have been abused or neglected receive the support and care they need for their safety and wellbeing", and
- Supporting Outcome 6 "Child sexual abuse and exploitation is prevented and survivors receive adequate support" (Council of Australian Governments, 2009).

Whilst the timeframes for the National Framework have almost expired, the National Office of Child Safety (NOCS) was established in 2018 in response to the Royal Commission. The work of NOCS will build on the National Framework and the National Redress Scheme. NOCS is responsible for providing strategic leadership to support victims and survivors (adults and children) who have experienced child sexual abuse across their lifespan. Another deliverable is to build the capability of the service sector to respond to child sexual abuse.

The National Office for Child Safety is leading the design and implementation of Australia's first National Strategy to Prevent Child Sexual Abuse (the National Strategy). The National Strategy was a key recommendation of the Royal Commission and will focus on preventing child sexual abuse in all settings including in institutions, within families, and online. As recommended by the Royal Commission, the National Strategy will focus on prevention, including:

- changing culture and attitudes around child sexual abuse through education and awareness raising,
- supporting children who show harmful sexual behaviours,
- offender prevention interventions, and
- giving victims and survivors of child sexual abuse access to the right supports at the right time.

The National Strategy will also consider the unique needs of particular groups, including: Aboriginal and Torres Strait Islander communities, culturally and linguistically diverse communities, people with a disability, people who identify as LGBTIQ+, children (including youth in out-of-home care), and regional, remote and very remote communities.

4.11. Key international instruments

Sexual violence is a fundamental violation of human rights, as Article 5 of the Universal Declaration of Human Rights states that “No one shall be subjected to torture, or to cruel, inhuman or degrading treatment or punishment” (United Nations, 1948). Acts of sexual violence perpetrated against individuals by other individuals in peacetime are generally regarded as the domain of domestic criminal law, but sexual violence in the context of conflict is prohibited under customary international law (International Committee of the Red Cross, 2020), and offences can be prosecuted in international criminal courts.

Australia became a signatory to the Convention on the Elimination of all forms of Discrimination Against Women (CEDAW) in 1983. This international instrument requires signatories to promote policies, laws, structures and attitudes that promote gender equality and enable women to live free of discrimination (Australian Human Rights Commission, 2012). The States that have signed CEDAW have committed to take all appropriate measures to ensure that women can exercise and enjoy their human rights and fundamental freedoms (Australian Human Rights Commission, 2012).

In 1993, the United Nations General Assembly proclaimed the **Declaration on the Elimination of Violence Against Women**, designed to complement CEDAW. In this Declaration the UN stated that violence against women:

- constitutes a violation of the rights and fundamental freedoms of women,
- impairs or nullifies the enjoyment of rights and freedoms, and
- has long been neglected by governments and the international community

(Office of the High Commissioner of Human Rights, 1993).

The Declaration required that member states work to ensure that women subjected to violence have access to specialised assistance such as counselling and health services, to promote their safety and physical and psychological rehabilitation (Office of the High Commissioner of Human Rights, 1993). Violence against women was noted to be an obstacle to the achievement of “equality, development and peace” (Office of the High Commissioner of Human Rights, 1993).

More recently, the **United Nations 2030 Agenda for Sustainable Development** has maintained the connection between gender inequality and development. A specific Sustainable Development Goal on Gender Equality is embedded, and targets relating to ending all forms of discrimination against women and eliminating all forms of violence against all women and girls, including sexual exploitation, form part of the document (Commonwealth of Australia, 2019). However, the Human Development Report’s Gender Inequality Index shows that overall progress in gender inequality has been slowing in recent years (United Nations Development Programme, 2019). Gender inequality remains a persistent form of inequality around the world.

Another international instrument relevant to specialist sexual violence services is the **Convention on the Rights of the Child (CRC)**. Australia signed and ratified the CRC in 1990, and it has been ratified by every country in the world except the United States (Australian Child Rights Taskforce, 2016). Articles 19 and 35 require signatories to take steps to protect children from sexual exploitation and abuse, and Article 19 requires signatories to establish or maintain programs that can provide support for children and their carers affected by

violence and abuse, as well as facilitate investigation, treatment and follow up (UNICEF, 2020). The Australia Child Rights Taskforce, in its report on the commitment of the Australian Government to the CRC, made a number of recommendations relating to children in Australia who experience neglect and abuse (including sexual abuse). The taskforce recommended adequately funding and prioritising the National Framework for Protecting Australia’s Children and the Third Action Plan (current at the time the Report was written) under the National Plan to reduce violence against women and their children (Australian Child Rights Taskforce, 2016).

5. Standards

5.1. What are the Standards?

In this edition of the Standards, the 10 Standards in the previous edition have been condensed into seven Standards and reorganised around the concept of what is valued in effective specialist sexual violence services.



1. Valuing access for all clients

This Standard encourages practitioners and organisations to identify and remove barriers to service provision, so that sexual violence services are accessible, safe places for all

2. Valuing client experience at the service

This Standard reinforces the importance of clients having a positive experience when they engage with sexual violence services

3. Valuing sound clinical interventions

This Standard provides a high-level overview of considerations when delivering clinical services to clients, and contains guidance relating to the specific needs of some client groups

4. Valuing advocacy, collaboration and community engagement

This Standard explores ways in which sexual violence organisations should be extending their work beyond the service they are employed by, and forging connections in their local communities

5. Valuing staff

This Standard highlights the importance of investing in the professional knowledge and physical and mental wellbeing of all staff working in sexual violence services

6. Valuing a stable organisation, good governance and effective systems

This Standard focuses on the systems and administrative practices that sexual violence services need to have in place to ensure the smooth operation of the service

7. Valuing innovation and quality improvement

This Standard encourages sexual violence services to keep growing and building on new research, knowledge and developments in the sector

5.2. Why have we used the term “valuing”?

Some of the definitions of “value” in the Collins English Dictionary include:

- The desirability of a thing
- Worth, merit or importance
- The beliefs and accepted standards of a person or group
- To have a high regard for, especially in terms of worth, merit, usefulness etc (HarperCollins, 2021).

Organising the Standards around the concept of what is valued stemmed from discussions with the Steering Committee, in which the observation was made that one crucial factor that seems to distinguish effective organisations in the sector from organisations that fall short of expected standards, is whether the management and staff really care about the work and the clients of the service.

By naming what must be valued by effective specialist sexual violence services – using the definitions above, what is regarded as desirable, important, accepted standards, useful - we aim to highlight the most important considerations for organisations and support the implementation and delivery of high-quality services for victim-survivors across the country.

5.3. Meeting and Exceeding National Standards

In this edition of the Standards, we have moved away from the concept of “minimum” and “best” practice, to “Meeting national standards” and “Exceeding national standards”.

All specialist sexual violence services should be meeting national standards, and organisations with advanced practice may be exceeding national standards in one or more areas. Services who can demonstrate that their practice exceeds national standards are also likely to be well resourced and well-funded, who have managed to retain skilled staff and Board members.

The Standards locate responsibility for meeting each Standard with:

- the organisation, which at times mean the board of management or at other times the clinical or line manager as the agent of the organisation, or
- all staff, which refers to clinical, administrative and support staff, or
- clinical staff, encompassing staff who deliver medical and psychological services to clients.
- counselling staff, where the Standard is relevant only to staff delivering psychological care and support to clients.

While these Standards are not intended to provide detailed guidance to medical staff who work in sexual violence services, they are often exposed to traumatic material in their roles and therefore their wellbeing must be taken into consideration. Also, professionals such as doctors are generally respected in our society and therefore the messages that medical staff convey about

responsibility for sexual violence, possible responses to trauma and treatment options can significantly influence victim-survivors, and potentially undermine the views of other professionals. For this reason, medical staff working in the sector must ensure that their approach is consistent with these Standards.

Where responsibility is located with staff, it is assumed that managers adequately resource staff and ensure they have been given opportunities to equip themselves to meet these responsibilities.

5.4. Structure of each Standard

The structure of each Standard is as follows:

- the overarching standard is stated
- a preamble provides the rationale for the points that follow. This section draws on the Literature Review completed in the earlier stage of this project, other relevant research and input gained in the consultation phase
- relevant considerations relating to the overarching Standard are addressed in turn, and practice that meets and exceeds the national standards is identified
- where responsibility for meeting each Standard rests is noted – either with the organisation, all staff, clinical staff or counselling staff, or a combination of these.

STANDARD 1

Valuing Access for All Clients

Systemic discrimination and structural barriers may exclude people from diverse groups from accessing specialist sexual violence services. Services should work to identify barriers to access and adapt their policies and practices to remove these barriers. Working to increasing access aligns with the foundational frameworks of specialist sexual violence services, including social justice, intersectionality, anti-oppressive practice and person-centred care.

To increase access for clients of diverse groups, organisations must be culturally safe. Cultural safety is the act of fostering a safe and respectful environment which recognises and respects the specific cultural needs of an individual or community. Culturally safe practice recognises that there are power relations in and between all cultural groups and at all levels (Commonwealth of Australia, 2017) and so critically engages with how people's health and safety is influenced by historical, political and socioeconomic contexts.

Services that are yet to embed cultural safety in their organisation are at risk of indirectly discriminating against clients from diverse backgrounds, including Aboriginal and Torres Strait Islander peoples, by failing to identify and remove cultural barriers to service provision (Commonwealth of Australia, 2017).

Intersectionality has been gaining importance internationally as a framework to offer a deeper understanding of the complexity of diverse social identities and the impact of social structures on power, privilege, and oppression to guide service. Sexual violence services should undertake an intersectional approach to service provision that recognises oppression and social disadvantage as institutional and systemic, embraces diversity and inclusion and acknowledges the expertise of specific population groups in the provision of services to their communities. Where individuals and community-based organisations share their expertise with specialist sexual violence services, their



time and knowledge should be appropriately remunerated. At the core of service delivery must be inclusion, equity and diversity and the right of Aboriginal and Torres Strait Islander peoples to determine their own path to recovery.

Evidence suggests that, despite significant effort to respond to community diversity, there remains gaps in service support for certain population groups impacted by sexual violence (State of Victoria 2017; Wharewera-Mika 2016). Victim-survivors may experience discrimination or barriers to accessing services on the basis of gender, sexual orientation, ethnicity, language, socioeconomic status, geographic location, disability, age or any intersection of these. Services should adopt an intersectional approach to respond to the needs and experiences of diverse groups including:

- people from diverse cultural and faith-based backgrounds
- LGBTIQ communities
- Aboriginal and Torres Strait Islander communities
- people with disability
- older people
- children and young people.

While the provision of face-to-face services is the preferred method for supporting victim-survivors of sexual violence, a person-centred approach requires services to be flexible in their methods of service delivery. Issues such as geographic location, mobility and language may act as barriers to

access, and services should be prepared to minimise these barriers.

1.1 Increasing access for clients from diverse groups

Increasing access to sexual violence services for clients from diverse groups is an ongoing process whereby the organisation analyses the demographic data it has collected in order to ensure that the organisation is inclusive and culturally safe for all members of the community to access. Where certain population groups are noted to be underrepresented, the organisation works to identify what the barriers to accessing services might be and what can be done to improve access. Where possible, clients receive support and any assistance needed to fully engage with services.

Meeting National Standards

There is evidence that the organisation:

- is committed to improving access to services and is actively engaged in reducing access barriers to its service by embedding culturally safe practices
- is non-discriminatory in the programs and services it delivers, offering services to all eligible clients in an equitable manner
- participates in community events and networking opportunities to raise the profile of the organisation
- provides information about the organisation and services offered in community languages, accessible English, and information suitable for children and young people
- has ensured that all marketing material, including website design, reflects the diversity of the communities it serves
- has ensured that all intake forms and data collection systems are inclusive of clients of diverse genders
- remunerates individuals and representatives of community-based organisations who share their knowledge and expertise with the specialist sexual violence in the interests of increasing access
- has distributed marketing material in public spaces in the community, such as community centres, libraries, doctor's surgeries

There is evidence that all staff:

- enquire about any accommodations potential clients require in order to access the service
- ensure that steps have been taken to accommodate any additional needs prior to the initial appointment, where appropriate
- undertake training to increase their understanding of the specific needs of clients from diverse groups

There is evidence that clinical staff:

- seek to educate themselves about the cultural and religious backgrounds of their clients
- undertake training to build their skills in working with clients from diverse groups
- ask clients at risk of dropping out of the service, particularly those from diverse backgrounds, about any difficulties they are experiencing in accessing the service or attending sessions

Exceeding National Standards

<p>There is evidence that the organisation:</p>	<ul style="list-style-type: none"> • consults with marginalised groups to identify needs and barriers to service delivery • employs an appropriately qualified staff member to publish a website and/or manage social media channels, to improve engagement with diverse groups • employs a community development worker • makes a diversity of marketing material available, including resources that target men and the LGBTIQ+ community
<p>There is evidence that clinical staff:</p>	<ul style="list-style-type: none"> • seek and access cultural consultations when working with clients of diverse backgrounds

1.2 Minimising financial constraints

The organisation recognises that charging fees creates a barrier to accessing services and offers services free of charge.

Meeting National Standards

<p>There is evidence that the organisation:</p>	<ul style="list-style-type: none"> • Provides all services free of charge, including groups • There are policies and procedures in place to ensure that clients who do not have a Medicare card can also access the service free of charge
<p>There is evidence that all staff:</p>	<ul style="list-style-type: none"> • Routinely advise potential clients on first contact that there is no charge for accessing services

Exceeding National Standards

There is evidence that the organisation:	<ul style="list-style-type: none">• has taken steps to mitigate incidental costs of accessing the service, such as costs of transport, parking, and childcare fees• advocates on a systems level to reduce financial barriers to victim-survivors accessing services
There is evidence that clinical staff:	<ul style="list-style-type: none">• advise clients of sources of funding or other resources that can reduce incidental costs associated with accessing the service, and with their consent, facilitate access to these• advocate for their clients (within the organisation and externally, where required) when incidental costs relating to accessing the service are identified

1.3 Using interpreters

The use of interpreters can increase access to services and improve the organisation’s understanding of client needs and issues.

Meeting National Standards

There is evidence that the organisation:	<ul style="list-style-type: none">• has policies and procedures in place regarding the use of interpreters• informs clients of their rights to, and the availability of, interpreters - in written material, on websites and over the phone• requires the use of qualified interpreters rather than friends or family members• budgets for the use of interpreters
There is evidence that all staff:	<ul style="list-style-type: none">• have received training in relation to working with interpreters, both face to face and over the phone

There is evidence that clinical staff:

- consider the appropriateness of the gender of the interpreter
- consider whether it may be more appropriate to use a telephone interpreter rather than a face to face one in situations where the client belongs to a small community
- ensure that interpreters are adequately briefed before and after sessions where possible
- are aware that a client who is conversant in English may require an interpreter in situations of increased stress or where complex concepts will be discussed, such as giving evidence in court or when discussing medical treatment/ issues or child protection concerns
- recognise the experience of vicarious trauma by interpreters and offer or recommend debriefing/defusing

1.4 Augmentative and alternative communication (AAC)

Some clients with disabilities may require the use of alternative communication technologies to access services, particularly medical intervention, and counselling.

Meeting National Standards

There is evidence that the organisation:

- has policies and procedures in place which support clients who use AAC accessing the service
- provides awareness training to all staff in the use of AAC
- provides information on its website about how to contact the organisation if you use AAC
- budgets for the use of AUSLAN interpreters and the purchase/maintenance of any technologies required to provide services to clients who use AAC
- offers an alternative to telephone calls as a way to make an initial contact with the service e.g., webchat

There is evidence that all staff:

- when a victim-survivor has known communication needs, enquire about ways to maximise communication, prior to the initial presentation to the service
- are familiar with how to make calls via the National Relay Service
- know how to book an AUSLAN interpreter

There is evidence that all clinical staff:

- have the capacity to assess communication needs
- have access to tools to increase the capacity of victim-survivors with communication needs to access services
- modify and adapt usual clinical and counselling practice as required
- access specialist supervision or undertake additional professional development when working with clients who use AAC

1.5 Accessible, client-friendly spaces

The spaces which clients use within the organisation, including entrances and exits, walkways, waiting areas, toilets, counselling, and group rooms, must be accessible and client friendly.

Meeting National Standards

There is evidence that the organisation:

- has assessed client spaces and considered their accessibility for clients with a range of needs, including mobility issues, sensory issues, those attending with children or companion animals
- recognises the importance of creating a welcoming environment and maintains the building
- has arranged waiting areas to afford individuals a sense of privacy and to mitigate re-traumatisation
- has posters and written materials on display in the waiting area in a range of community languages and supporting the access of diverse groups of clients e.g., children and young people, men, LGBTQ+ clients

There is evidence that all staff:

- seek to ensure that clients feel welcome in the service, particularly when they attend the service for the first time

Exceeding National Standards

There is evidence that the organisation:

- has an outdoor area for the use of clients and/or companion animals
- has a selection of children's toys and books
- provides free tea and coffee making facilities
- seeks the input of clients as to ways to improve spaces within the organisation that they use

1.6 Flexibility in how counselling is delivered

Whilst providing specialist sexual violence counselling face to face remains the gold standard, many services, especially those in rural and remote locations, may need to offer services in alternative ways. Even in metropolitan locations, some clients may have a preference for accessing service remotely, for a range of reasons. Remote provision of counselling has been a necessity for many services in 2020 due to restrictions related to COVID-19. Now that services have experience delivering services remotely, this expertise can be drawn on again in times of disruption caused by illness or natural disasters, or simply to decrease the barriers for some clients to accessing support. Organisations will endeavour, where practicable, to establish counselling modes alternate to face to face.

Meeting National Standards

There is evidence that the organisation:

- has policies and procedures in place to support high-quality service provision where counselling is offered via telephone, video technology or webchat
- uses secure systems to protect clients who access services in these ways, particularly web chat or video technology
- employs qualified and experienced trauma counsellors to work on telephone and webchat support systems and provides these counsellors with the same level of support and supervision as face-to-face counsellors
- provides additional training to counsellors who will be delivering counselling via telephone, video technology or webchat
- has systems in place to enable the development of therapeutic goals, reviewing progress against goals and outcome evaluation
- through clinical supervision, assesses on a case-by-case basis how appropriate it is to move from face to face to an alternative mode of counselling
- maintains client files for clients who access the service only via telephone counselling or webchat
- offers referrals to other appropriate telephone or online counselling services if the organisation is unable to provide telephone counselling or online support, on their telephone answering system and/or website

There is evidence that all clinical staff:

- where appropriate, offer the client flexibility and choices around how to engage with the service to best meet their needs
- consider client preferences but also apply clinical judgment when making decisions about alternative modes of service delivery
- particularly when working with children and young people, clinicians consider alternative locations for service delivery, when necessary, to increase a child or young person's sense of comfort and security
- endeavour to minimise disruption to children and young people's education by offering appointments outside of school hours

Exceeding National Standards

There is evidence that the organisation:

- delivers services in innovative ways to clients belonging to diverse groups in the community who are not comfortable with mainstream models of service delivery
- seeks feedback from clients to improve the experience of using telephone counselling, webchat, or video technology
- explores new technology and new modes for providing counselling to clients

1.7 Offering outreach services

Where practicable and resources permit, organisations will establish mechanisms to enable outreach services.

Meeting National Standards

There is evidence that the organisation:

- recognises that outreach services involve increased costs and resource appropriately
- expects the same standards of clinical practice in outreach services as the care delivered in the primary site
- evaluates its outreach services
- has policies in place addressing the work health and safety of outreach service provision
- requires risk assessment and safety procedures to be in place prior to any services being delivered in an unfamiliar location, to ensure the safety of clients and staff

There is evidence that all clinical staff:

- take into account client preference, confidentiality and any other relevant matters, and use clinical judgement when determining an appropriate location for service delivery

Exceeding National Standards

There is evidence that the organisation:

- partners with community-based organisations to deliver outreach services in their premises, and remunerates the organisations appropriately

1.8 Increasing access for Aboriginal and Torres Strait Islander peoples

Colonisation, dispossession of lands and government policies including forced removal of children, alongside other forms of violence, loss and discrimination, have caused historic and ongoing trauma for many Aboriginal and Torres Strait Islander peoples, families and communities. It is important to recognise that Aboriginal and Torres Strait Islander peoples are not one singular group, but diverse and multicultural.

Aboriginal and Torres Strait Islander peoples face significant barriers in accessing mainstream services. Specialist sexual violence services must adapt their practice to improve access. Aboriginal and Torres Strait Islander peoples possess great strength and resilience, and many have deep, ongoing connections to their culture, kinship, family and history. Cultural practices within Aboriginal communities can facilitate the healing of victim-survivors and must be acknowledged.

Meeting National Standards

There is evidence that the organisation:

- allocates time and resources to build relationships with Aboriginal and Torres Strait Islander communities
- has identified and built relationships with Aboriginal and Torres Strait Islander cultural consultants, elders and other community leaders
- remunerates cultural consultants/brokers for their time and expertise
- is aware of strengths, resources and needs in the local Aboriginal and Torres Strait Islander community
- seeks the input of the local Aboriginal and Torres Strait Islander community into service design and delivery
- offers outreach appointments to Aboriginal and Torres Strait victim-survivors, so that they can access services in environments in which they feel safe
- collaborates with Aboriginal and Torres Strait Islander health services and other community-based organisations and promotes the specialist sexual violence service through culturally appropriate marketing materials at these services
- supports Aboriginal and Torres Strait Islander employees to obtain qualifications or further their education in aligned fields of practice
- through clinical supervisors, maintains oversight of cultural consultation processes
- remunerates individuals and community-based organisations who share their knowledge with the specialist sexual violence service in the interests of increasing access for Aboriginal and Torres Strait Islander peoples

There is evidence that all staff:

- have undertaken Aboriginal cultural competency training, and have specific knowledge of the local Aboriginal community's cultural practices
- understand the broader context of the past experiences of Aboriginal people and how these influence service engagement and experiences of sexual violence

There is evidence that all clinical staff:

- recognise that Western models of therapeutic support may not be appropriate or helpful for Aboriginal and Torres Strait Islander victim-survivors
- seek Aboriginal and Torres Strait Islander cultural consultation, being mindful of potential conflicts of interest, and maintain confidentiality as to the identity of the Aboriginal cultural consultant
- place records of Aboriginal and Torres Strait Islander cultural consultations on the client's file
- work to support resilience and healing in responses to sexual violence
- in therapeutic work with Aboriginal and Torres Strait Islander victim-survivors, support and strengthen relationships with non-abusive family and kin, and draw upon connections to culture
- demonstrate knowledge of and respect for Aboriginal and Torres Strait Islander worldviews
- where appropriate, offer flexibility in the location, meeting times and duration of appointments
- offer an Aboriginal worker or support person to participate in appointments if an Aboriginal staff member is not available
- work collaboratively with Aboriginal staff or organisations, where possible
- challenge racism as part of individual and systems advocacy
- seek feedback from the community about outcomes
- always protect the privacy and confidentiality of the client within their community
- provides physically appropriate spaces (including outdoor) for Aboriginal and Torres Strait Islander children and families to come together to access services
- has Aboriginal identified positions

Exceeding National Standards

There is evidence that the organisation:

- has Aboriginal and/or Torres Strait Islander workers available to undertake culturally appropriate intake, referral, assessment and service responses to Aboriginal and Torres Strait victim-survivors and their families
- adopts a cultural brokerage model when engaging with Aboriginal and Torres Strait Islander clients
- offers Aboriginal and Torres Strait Islander victim-survivors choice about whether the clinical staff allocated to them are Aboriginal or non-Aboriginal

Organisations should ensure their practices are congruent with the:

- [Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2016-2026](#);
- [National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework 2016-2023](#); and the
- [National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017-2023](#).

1.9 Incorporating intersectionality into practice

Victim-survivors' vulnerability and responses to sexual violence are influenced by their identities and social attitudes towards these identities. Help seeking behaviours are also influenced by past experiences of discrimination and exclusion. Victim-survivors from marginalised communities, and even more so those who belong to multiple marginalised communities, face significant barriers to accessing services. Organisations must look for ways to adapt their practice to make services more responsive to all victim-survivors, rather than expecting clients to adapt to their preferred ways of working.

Meeting National Standards

There is evidence that the organisation:

- recognises that people from diverse communities have fundamentally different experiences of sexual violence
- has embedded the concept of intersectionality in policies and procedures
- works to eliminate barriers to service provision
- seeks the input of diverse groups into service planning, delivery and evaluation, and remunerates individuals and organisations for their time
- funds diversity and intersectionality training for all staff

There is evidence that all clinical staff:

- do not stereotype individuals based on their identity/ies, but seek to understand the worldview of each victim-survivor and the complexity of their experience of sexual violence
- tailor a response to individual victim-survivors considering their diverse characteristics, attributes and experiences, and their preferences and perspectives
- critically reflect on their practice when working with individuals from multiple marginalised communities
- seek feedback from victim-survivors about their experiences in the service to improve practice
- seek out experts in allied services that serve specific communities to increase their understanding of the background of the clients they are working with

1.10 Advising clients of their rights and responsibilities

Clients need to understand their rights and responsibilities when engaging with an organisation.

Meeting National Standards

There is evidence that the organisation:

- provides clear and accessible written and verbal information to all clients regarding their rights and responsibilities
- has addressed topics such as the terms of service, policies and procedures relating to confidentiality and consent, and mechanisms for making complaints in the rights and responsibilities information
- ensures developmentally appropriate information is available for children and young people
- advises clients of how to make a complaint when they feel their rights have not been upheld
- has a complaint handling process in place and the organisation has responded to complaints
- advises clients of their rights to make complaints to external agencies, such as professional bodies and/or the Australian Health Practitioners Regulation Agency (AHPRA)

There is evidence that all counselling staff:

- discuss a counselling agreement with new clients to ensure that they understand their rights and responsibilities and can give informed consent. This counselling agreement is signed by both the counsellor and the client and forms part of the client file.

1.11 Being proactive and trauma informed to facilitate engagement

The manner in which sexual violence specialist services engage with victim-survivors of sexual violence is shaped by their knowledge about the impacts and effects of trauma and complex trauma. Organisations and staff recognise the influence that experiences of trauma can have on how victim-survivors relate to others, particularly those in positions of power, such as professionals.

Meeting National Standards

There is evidence that the organisation:

- has policies and procedures that are trauma-informed, particularly around client engagement, follow up and missed appointments
- recognises the adaptive intent behind many trauma associated behaviours, some of which may emerge in interactions with staff
- takes steps to avoid or reduce the risk of retraumatisation of victim-survivors by contact with the service and any interventions offered
- is aware that trauma can impact on families and communities, which is particularly evident when working with Aboriginal and Torres Strait Islander communities
- offers counselling session to clients based on their individual needs and does not impose arbitrary caps on the number of sessions
- welcomes clients with complex trauma histories, recognising that they may have complex needs, and may require long term clinical intervention, case management and advocacy

There is evidence that all staff:

- adopt a non-judgmental stance
- are trauma-informed in their interactions with victim-survivors
- critically reflect on difficult interactions with victim-survivors and seek to make sense of these in terms of the way that trauma can impact on victim-survivors
- strive at all times to ensure clients feel welcome in the organisation, respected and heard

There is evidence that clinical staff:

- take a proactive approach to engaging potential clients and following up current clients, being persistent and adaptive but respectful
- work in a collaborative way with victim-survivors to build a therapeutic alliance
- demonstrate predictability, honesty, transparency, and trustworthiness in order to create a sense of physical and emotional safety
- offer choices and information to victim-survivors
- work to empower victim-survivors and foster autonomy, recognising that people, including children and young people, should be heard by those working to support them
- reflect the resilience of victim-survivors and seek to engender hope

1.12 Diverse workforce

The organisation recognises the richness that comes from a diverse workforce and actively seeks to recruit staff that reflect the wider community in which the organisation is situated.

Meeting National Standards

There is evidence that the organisation:

- abides by anti-discrimination legislation, promotes equal opportunity and affirmative action principles in its recruitment practices
- monitors management and staff profiles to ensure they are reflective of the diversity of service users
- has Board members from diverse backgrounds

Exceeding National standards

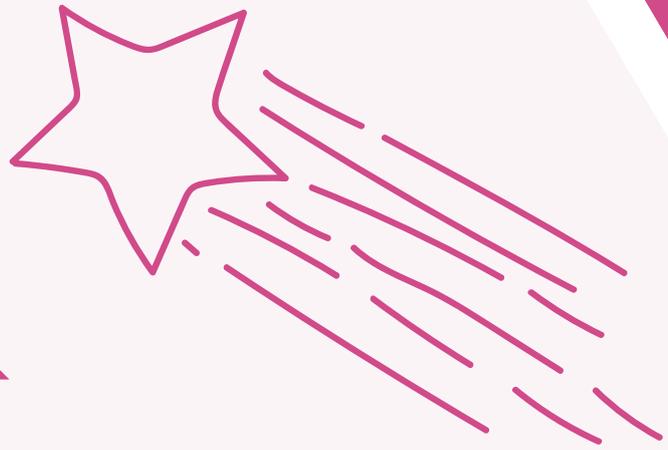
There is evidence that the organisation

- has Identified Positions within its counselling team, or undertakes targeted recruitment (care should be taken to ensure these processes are consistent with anti-discrimination obligations)
- offers choice regarding the attributes of their counsellor where appropriate – e.g., the client may be offered a male, Aboriginal, CALD or LGBTIQ+ counsellor
- demonstrates a culture of inclusivity with a wide range of population groups represented across management, staff and consumer representative groups

There is evidence that all staff:

- have undertaken unconscious bias training or equivalent

STANDARD 2



Valuing Client Experience at The Service

In recent years, there has been an increased recognition that the voices and lived experiences of victim-survivors should be at the centre of services. Organisations must actively seek the feedback of clients to improve service delivery and ensure that they are meeting client needs. Whenever organisations are considering new initiatives and programs, they should consult with victim-survivors, particularly clients from diverse backgrounds. With the input of Aboriginal and Torres Strait Islander women, services can potentially develop exciting new initiatives with and for Aboriginal and Torres Strait Islander victim-survivors.

The concept of trauma-informed care is now being widely embraced among sexual violence services, and by health professionals more broadly. Many of the principles of trauma-informed care have been part of practice in specialist sexual violence services, although the term has not been widely used in the sector. Key principles underlying trauma-informed care include:

- **Safety** – ensuring physical and emotional safety
- **Choice** – individuals have choice and control
- **Empowerment** – prioritising enablement and skills building
- **Trustworthiness** – task clarity, consistency, interpersonal boundaries
- **Collaboration** – sharing decision making and power (NSW Agency for Clinical Innovation, 2019).

Sexual violence services need to be aware of and understand both complex and intergenerational trauma and be mindful of how these experiences may manifest when clients present to services. The victim-survivors' experience at the service must counteract the dynamics and effects of sexual violence – they should be given options and choices, must be asked to give informed consent to any interventions and should feel empowered by their engagement with the service. When victim-survivors make contact with a specialist sexual violence service for the first time, they may



be in crisis, so services must be resourced to attend to them as quickly as possible and have guidelines in place for prioritising cases when they are at capacity.

A trauma-informed approach should also acknowledge how trauma can exist within experiences of structural oppression. For example, high rates of sexual assault perpetrated against Aboriginal and Torres Strait Islander women and their children need to be viewed in an historical context, alongside issues such as systemic racism, high rates of child removal and incarceration (Commonwealth of Australia, 2019). This intergenerational trauma can impact subsequent generations through community violence, poor physical and mental health, issues with attachment and parenting and multiple bereavements (Salter et al., 2020).

2.1 The practice and procedures in specialist sexual violence services are congruent with the principles of trauma-informed care

Organisations must ensure that procedures and clinical practice are informed by the complex and diverse impacts of trauma and the principles of trauma-informed care.

Meeting National Standards

There is evidence that the organisation:	<ul style="list-style-type: none">• is working towards embedding the principles of trauma informed care in its policies, procedures, and practice• has undertaken an audit of the service to identify the next steps it needs to take to progress along the continuum to become trauma informed• all staff have a common understanding of the impacts and effects of trauma, complex trauma, and intergenerational trauma
There is evidence that clinical staff:	<ul style="list-style-type: none">• incorporate the principles of trauma informed care in their clinical work• highlight ways to improve organisational practices to better align them with the principles of trauma informed care• actively seek to avoid retraumatisation• have undertaken training to enhance their skills in relation to conducting assessments, counselling, and case management with clients with histories of trauma

Exceeding National standards

There is evidence that the organisation	<ul style="list-style-type: none">• has modified relevant aspects of the service delivery system to ensure consistency with the principles of trauma informed care
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2.2 Clients are physically and emotionally safe when accessing the service

Victim-survivors must feel both physically and emotionally safe at the specialist sexual violence service in order for their contact with the organisation to assist in their recovery.

Meeting National Standards

There is evidence that the organisation:

- recognises that victim-survivors should be protected from further violence
- maintains the organisation's physical spaces to prevent risks of accidental injury
- maintains adequate oversight of clinical practice to ensure that staff are working in safe ways
- assesses the safety of outreach locations, for both the staff member and the clients
- has measures in place to protect victim-survivors and their family members from potential harm if the organisation also sees people who perpetrate sexual violence, children with problem sexual behaviours or young people who exhibit sexually abusive behaviours
- has ensured all staff are trained in responding to a range of emergency situations
- has plans in place to ensure ongoing service provision if a staff member becomes unwell, goes on leave or resigns from their position
- has installed sufficient security systems in the building to protect the safety of clients
- ensure that physical spaces where client engagement occurs afford an appropriate level of privacy

There is evidence that all staff:

- prioritise and promote client safety
- are mindful of client safety when attempting to get in contact or leave messages
- have undertaken training and are confident in responding to a range of emergency situations
- ensure all client-related information is safe from being observed, and any discussions related to clients cannot be overheard, by visitors to the service and other clients

There is evidence that clinical staff:

- always enquire about ongoing violence or perceived risk of future violence at the point of first contact with a victim-survivor
- undertake a comprehensive risk assessment with all clients, and repeat risk assessments when this is indicated by changes in circumstances
- create safety plans with clients where this is clinically indicated
- work to create an environment of emotional safety in counselling and groupwork sessions
- take a stage-based approach to recovery (see Standard 4)
- allow clients to work at their own pace to prevent emotional overwhelm
- are guided in their practice by the best available evidence as to what is safe and effective (see also Standard 3)

2.3 Clients are given options and choices wherever possible

By its definition, any act of sexual violence takes away choices from an individual, as they are forced, tricked, or coerced into to sexual acts. In counteracting the impacts and effects of sexual violence, organisations must offer choices to victim-survivors, wherever possible.

Meeting National Standards

There is evidence that the organisation:

- seeks informed consent in relation to all services and interventions offered by the organisation (see also 2.7)
- seeks informed consent from children in age-appropriate and developmentally-appropriate ways and to include children in any decision making processes that affect them
- asks clients about the preferred gender of any interpreter being used, and seeks to have this preference reflected in the booking
- offers clients the option of having a support person present for any interventions
- seeks to cater to client's preferences regarding the gender, religious or ethnic background, sexuality or other characteristics of clinicians involved in their care
- advises clients of their right to request an alternate counsellor – either within the service or through referral to an external agency

There is evidence that clinical staff:

- advise clients of their right to refuse a service or withdraw consent at any time (see also 2.7)
- discuss alternative treatment options with clients, offering information about advantages and disadvantages of different approaches
- discuss alternate service providers and possible referrals
- adapt their practice based on the client's goals and preferred ways of working
- where possible, offer flexibility about the counselling delivery mode and location of counselling services

Exceeding National Standards**There is evidence that the organisation:**

- has a diverse clinical team with, for example, a male counsellor, a counsellor that identifies as LGBTIQ+, an Aboriginal counsellor, counsellors with the same racial or ethnic background as a range of groups in the community, (or a combination of these) and gives clients the option to choose a clinician that aligns with their own identity or preferences

2.4 Clients are empowered by their contact with the service

Given the inherently disempowering nature of experiences of sexual violence, it is essential that clients feel empowered by their contact with the organisation. This can be achieved through practices discussed at various points in these Standards, such as obtaining informed consent, offering choices, working collaboratively, and seeking feedback, but organisations and clinical staff can take additional steps to foster empowerment.

Meeting National Standards**There is evidence that the organisation:**

- in its messaging around sexual violence, locates responsibility for sexual violence with offenders and communicates belief and the promise of non-judgmental support to all victim-survivors
- has embedded empowerment in its clinical practice
- through clinical supervision, encourages clinical staff to reflect on their professional boundaries with clients and how their work supports client growth and independence

There is evidence that clinical staff:

- are realistic about possible outcomes, both at a systems level and in counselling
- allow clients to work at their own pace in counselling
- work from a strengths-based perspective, recognising and drawing attention to examples of the client's resilience, determination, and positive changes that they have made
- support clients to recognise what is within their control
- foster autonomy and skill building rather than dependence on the organisation or clinician
- with progress in counselling, support clients to increasingly advocate for themselves
- critically reflect on the appropriateness of increasing contact with a client or offering services over the long term
- share opportunities for client input into service design or social action, where appropriate
- carefully plan closure with clients, particularly clients who have attended long term counselling
- support clients to see closure at the service as an achievement, and evidence of recovery and growth

2.5 Clients learn that they can trust the organisation and its staff

It is important for organisations and their staff to be transparent in their processes to build the client's trust in the organisation. Many clients with histories of sexual violence have experienced profound betrayals of trust in the past, and may have difficulty trusting others, including professionals, or trusting institutions. Organisations and their staff must be consistent, clear about roles and boundaries and make the processes of the organisation transparent to demonstrate to clients that they are trustworthy.

Meeting National Standards

There is evidence that the organisation:

- keeps a copy of the organisation's policies and procedures, and other relevant documents (such as these Standards) in a public area such as the waiting room, to be accessed by clients
- are consistent and predictable in their application of policies and procedures
- addresses any boundary violations by staff

There is evidence that all staff:

- recognise the importance of predictability and consistency in the delivery of services to victim-survivors
- appreciate that clients may take some time deciding whether and how to engage with the service
- are approachable and welcome questions and concerns raised by clients as an opportunity to improve service provision
- routinely provide written and verbal information about client rights and responsibilities
- give clients opportunities to ask questions about the organisation's processes and all aspects of service delivery
- maintain appropriate interpersonal boundaries with clients (both in person and via social media)

There is evidence that clinical staff:

- adhere to the expectations of their professional bodies regarding relationships with clients/former clients
- critically reflect on their interpersonal boundaries in clinical supervision
- endeavour to be a stable figure in the client's life, giving the client notice wherever possible of any changes to usual routines e.g., holidays, absences

2.6 Staff work in a collaborative way with clients

Specialist sexual violence services demonstrate respect for the resilience and insight of victim-survivors by listening to their identified needs and priorities and working collaboratively with them to support them in their recovery. The feedback of those who have used the service is vital to understanding its effectiveness and addressing shortcomings to drive service improvement.

Meeting National Standards

There is evidence that the organisation:	<ul style="list-style-type: none">• actively seeks the input of clients into a range of aspects of service design and provision, through a variety of means including surveys, client feedback forms, client representation on the board (or equivalent) and client advisory committees• allows clients to provide anonymous feedback• prioritises the view of clients when planning or making changes to service delivery• implements changes recommended by clients, where these are feasible and clinically sound• advocates on a systems level when clients provide feedback regarding negative experiences with other services• seeks client input into other services that the organisation could/should offer
There is evidence that clinical staff:	<ul style="list-style-type: none">• continue to exercise their clinical judgement, but are client-led in their clinical work• ask clients to identify their goals and priorities in counselling• incorporate client satisfaction measures into their practice, routinely asking clients what could improve counselling sessions/clinical intervention• offer to share feedback to interagency partners when clients have had poor experiences, with a view to improving future service provision

Exceeding National Standards

There is evidence that the organisation:	<ul style="list-style-type: none">• consults with clients of the service regarding potential changes to service delivery• routinely asks clients to fill out a client satisfaction survey, and collates and publishes the data
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2.7 Informed consent is critical

Obtaining informed consent is not always a simple process and organisations must have a comprehensive and flexible system in place to ensure that all clients are fully engaged in the consent process, from initial contact through the file closure. Consent must be gained from clients for each new intervention/procedure, and clients can withdraw consent at any time. Seeking informed consent is central to demonstrating respect for a client and can assist staff to demonstrate trustworthiness and their desire to work with clients in a collaborative way.

Meeting National Standards

There is evidence that the organisation:

- has clear and rigorous policies and procedures to guide the consent process for all staff who have contact with clients
- is aware of relevant state/territory consent legislation and practices are consistent with legal obligations
- has processes in place whereby staff can seek guidance regarding a client's capacity to consent, including after hours
- has policies and procedures in place to respond to instances of conflict around consent between parents/guardians and children/young people

There is evidence that all staff:

- provide written and/or verbal information about processes and procedures, to ensure clients can give informed consent
- read documentation regarding consent and provide further explanation where there is doubt about a client's level of literacy
- provide information about processes and procedures in a developmentally appropriate manner
- advise clients of their right to decline services and withdraw consent at any time
- use interpreters to discuss consent where necessary
- give clients the option of having a support person present for discussions relating to consent
- move at the client's pace when discussing consent, with the understanding that it is difficult for clients to absorb new information when under emotional stress
- ask the client if they have any questions about the information provided

There is evidence that clinical staff:

- advise clients of any possible/likely adverse effects or consequences of interventions or treatments
- obtain written consent before consulting or sharing information with other professionals working with the client
- record any instances of consent granted verbally in the client file
- assess the capacity of a child or young person to give informed consent by ensuring they appreciate the risks, benefits and alternatives to clinical services
- carefully document their decision-making process when consent is sought from children and young people
- obtain lawful consent from the child or young person's parent or guardian if the child or young person is deemed unable to give informed consent
- involve children and young people in discussions with the parents/guardians about interventions, even where they are not able to consent

Exceeding National Standards

There is evidence that the organisation:

- encourages staff to engage with topic of consent and its related issues in team meetings, clinical supervision and/or professional development, particularly around the consent of minors and clients with impaired cognitive function

2.8 Organisations respond in a timely manner

Many clients are in crisis when they first contact a specialist sexual violence service, regardless of whether the sexual violence was recent or occurred in the past. Victim-survivors of recent sexual assault may need urgent medical attention or need to be seen within certain timeframes to maximise the possibility of forensic evidence being collected. Victim-survivors and/or their families/caregivers may require immediate psychosocial support. There may be ongoing child protection concerns. For all these reasons, it is important that specialist sexual violence services are appropriately resourced to respond to all client contacts as soon as possible.

Meeting National Standards

There is evidence that the organisation:

- has established service priorities to guide staff in responding to new clients and referrals,
- enables access to acute medical care
- prioritises immediate safety and support over administrative procedures
- has procedures in place to ensure that victim-survivors of recent sexual assault receive the acute care services they need as soon as possible, which may include medical care, medical-forensic services, police and/or child protection involvement, legal advice.
- makes contact punctually following an after-hours presentation to offer ongoing support to victim-survivors
- updates potential referrers about any changes to referral processes
- provides timely referrals to suitable alternative organisations when contacted by an individual who is not eligible for a service

2.9 Waitlist management

Whilst ideally eligible clients who contact a specialist sexual assault service for support can access counselling immediately, at times, demand for counselling services can outstrip available resources. This is challenging for both clients and staff. Where organisations establish a waiting list for counselling clients, they must have policies and procedures in place to ensure that clients in crisis or with high needs are prioritised, and that counselling clients can be allocated to staff in a prompt and equitable manner.

Meeting National Standards

<p>There is evidence that the organisation:</p>	<ul style="list-style-type: none"> • has a waitlist policy which clearly outlines criteria for the order in which cases are allocated • are actively pursuing strategies to reduce wait times for services • regularly reviews the effectiveness of wait list procedures
<p>There is evidence that all staff:</p>	<ul style="list-style-type: none"> • obtain consent from clients before adding their name to the waiting list • inform clients about how the wait list is managed • offer clients appropriate alternative referrals that could assist more quickly, and provide details of sources of after-hours support

Exceeding National Standards

<p>There is evidence that the organisation:</p>	<ul style="list-style-type: none"> • advocates for additional resources to reduce wait list times • allocates a counsellor to maintain contact with wait list clients on a regular basis, to check in on their wellbeing and advise them of progress on the waiting list
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STANDARD 3

Valuing Sound Clinical Interventions

What constitutes 'best practice' can be highly contested however it is an important concept for the development of effective service responses to violence against women (Breckenridge and Hamer, 2014). Practitioners should commit to ongoing learning regarding the impacts of sexual violence and trauma-informed therapeutic interventions, as the skills and knowledge of the practitioner are vital in ensuring sound clinical practice. Practitioners should also be aware of how the dynamics of sexual violence may result in challenges to help-seeking and engagement in counselling. Other key considerations for providing clinical services to victim-survivors of sexual violence include:

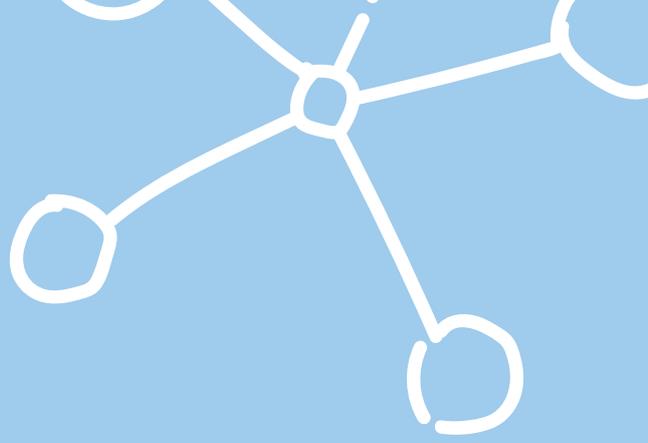
- the importance of the therapeutic alliance between the victim-survivor and practitioner
- flexibility to ensure counselling methods and therapeutic techniques are adapted to suit the individual needs of the victim-survivor
- ensuring effective psychosocial, and

safety and risk assessments

- maintaining appropriate boundaries
- offering support to significant people in the lives of victim-survivors, for example, working therapeutically within family systems.

Clinical staff must ensure that their practice is congruent with recommendations emerging from new research and developments in the field, for example:

- **Complex trauma:** Victim-survivors of sexual violence, including sexual assault and childhood sexual abuse, have often been subjected to multiple traumatic events which can have significant health consequences. While complex trauma is not a medical diagnosis, complex PTSD is now included as a diagnostic category in the ICD-11.
- **Intimate partner sexual violence (IPSV):** There is increased recognition that IPSV is a distinct form of sexual violence that requires a tailored and integrated



response from the sexual assault and DFV sectors. Survivors of IPSV are at increased risk of poor physical and mental health outcomes and complex trauma, which highlights the importance of an effective service response.

- **Children and young people with problematic or harmful sexual behaviours:** Services should be developmentally and culturally appropriate, considering the individual needs of the child or young person and their family (Meiksans, Bromfield & Ey, 2017). A best practice approach to working with children and young people who sexually harm includes a contextual and trauma-informed approach, early intervention, non-punitive responses that focus on behaviour change, the involvement of parents and carers, collaborative and multi-agency responses, and ensuring responses are culturally informed.
- **Working with Aboriginal and Torres Strait Islander victim-survivors and their families:** Many Aboriginal and Torres Strait Islander peoples find Western approaches to recovery from sexual violence alienating and ineffective (Breckenridge & Flax, 2016). Organisations and clinicians must adapt their practices to better align with Aboriginal and Torres Strait Islander cultural practices and build their knowledge of holistic understandings of health that are central to Aboriginal and Torres Strait Islander worldviews.

3.1 Clinical services are offered in a manner that is congruent with the foundational frameworks of specialist sexual violence services

Clinical interventions align with the foundational frameworks of specialist sexual violence services identified in section 4 of the introduction to the Standards.

Meeting National Standards

There is evidence that the organisation:

- utilises therapeutic models, services and programs that are informed by trauma research and practice
- identifies sexual violence as a gendered crime
- offers a degree of flexibility for victim-survivors, ensuring that care is person-centred
- draws on the concept of intersectionality and seeks to overcome the multiple barriers that victim-survivors may face in accessing services
- can clearly articulate the client groups and complexity of cases it is resourced to assist
- can clearly articulate the scope of supports it is resourced to provide (e.g., counselling, groups, advocacy, case management, court support etc.)
- locates responsibility for sexual violence with the person who perpetrated the sexual violence
- employs practitioners who have the knowledge and skills to provide therapeutic interventions in a manner consistent with the foundational frameworks of specialist sexual violence services
- has an integrated framework for coordinating intake assessment, wait list management, counselling, evaluation and exit

There is evidence that clinical staff:

- utilise therapeutic models appropriate to the level of complexity of the trauma, client needs and service capacity
- recognise that clients may present to the service at any or several points in their recovery and the therapeutic response must be appropriately flexible to meet their needs
- adopt a staged approach to trauma recovery
- ensure proposed clinical interventions are culturally appropriate and culturally informed
- allow time for the therapeutic relationship between the counsellor and the victim-survivor to develop
- seek to meet the client “where they are at” and come to understand their unique experience of the world and the meaning they have made of enduring sexual violence

Exceeding National Standards

- | | |
|---|---|
| There is evidence that the organisation: | <ul style="list-style-type: none"> implements a range of therapeutic evaluations, including objective progress review and evidence-based evaluations |
|---|---|

3.2 Intake and initial assessment

The purpose of intake is to gain an overview of their presenting issues and determine whether the service can meet some of their needs. Clients may contact services in crisis, so it is important that the response at initial contact be provided by an appropriately trained professional who is able to ensure that the introduction to the service is sensitive, supportive, and prompt.

All eligible clients that contact a specialist sexual violence service will be offered an initial psychosocial and safety assessment, which may also be known as an intake assessment. The purpose of the initial assessment is to gain an overview of the client's presenting issues, ongoing support and health needs, and current safety. In certain circumstances, medical, police or forensic assistance may need to be prioritised over this initial assessment.

Meeting National Standards

- | | |
|---|---|
| There is evidence that the organisation: | <ul style="list-style-type: none"> provides protocols for intake procedures to all relevant staff has provided all staff who may have contact with potential clients basic training in sexual assault service delivery recognises the unique work health and safety risks for all staff who potentially have contact with clients in crisis and has strategies in place to reduce and respond to these risks has established data collection systems that can adequately identify and describe the client groups (e.g., demographic, cultural data) has developed standard format intake procedures and initial assessments which provide the client with information and choices has intake procedures in place which routinely enquire about any children who may be impacted/involved reviews intake procedures regularly |
|---|---|

There is evidence that all staff:

- who may have contact with potential clients of the service have undertaken basic training in sexual assault service delivery
- are aware of forensic timeframes
- obtain consent from clients to begin the intake process and ensure consent has been explained in a developmentally appropriate manner for children and young people
- understand that intake records and initial assessments are part of the client file

Exceeding National Standards

There is evidence that the organisation:

- has qualified counsellors on an intake roster at all times
- allows only qualified counsellors to undertake initial assessments
- offers clients choices around the format of initial assessments – whether they are face to face, over the phone or conducted via telehealth
- endeavours to offer eligible clients ongoing counselling support from the staff member who undertook the initial assessment
- seeks input from clients about intake procedures when undertaking reviews

3.3 Need, and risk, are addressed as part of intake and initial assessments

Victim-survivors of sexual violence presenting to specialist sexual violence services will have a range of needs depending on their particular circumstances. Victim-survivors can be at risk of ongoing violence, self-injury or suicide. Children and young people who are victims of sexual violence, or the children of adult clients, may also have child protection issues that clinicians must assess.

Meeting National Standards

There is evidence that the organisation:

- has developed an assessment framework which enables identification of presenting needs, risk to client safety, and any dependent children

There is evidence that clinical staff:

- regard risk and need assessments as an integral part of service provision
- provide an explanation of the risk and needs assessment process to enable clients to participate in the process
- engage in regular and ongoing assessment, recognising the dynamic nature of an individual's risk and needs
- establish therapeutic plans, including goals for counselling, in collaboration with clients as soon as possible after counselling commences
- note where the client may need to engage with alternative services to meet identified needs and facilitate a warm referral, where this is welcomed by clients

Exceeding National Standards**There is evidence that the organisation:**

- regularly reviews its need and risk assessment framework against emerging findings from research literature

3.4 Clinical interventions with children/young people

Clinical interventions with children and young people who are victim-survivors of child sexual abuse (CSA) must be focused on the safety and wellbeing of the child, whilst supporting the individuals and systems around the child to appreciate and respond appropriately to their needs. Organisations and clinical staff must be responsive to the individual circumstances of each child that presents, and be conscious of their diverse needs, particularly children and young people in care, from Culturally and Linguistically Diverse backgrounds, LGBTQ+ identifying, Aboriginal and Torres Strait Islander children and young people, and those living in regional, rural and remote areas.

Meeting National Standards**There is evidence that the organisation:**

- have embedded the National Principles for Child Safe Organisations in their policies and procedures
- have policies and procedures addressing mandatory reporting requirements, working with children checks and other jurisdictional obligations
- understands the demands on clinical staff when working in a systemic way with children and young people, and this is reflected in their case load
- has a child-focused complaints handling process – see, for example, the Complaint Handling Guide on the National Office for Child Safety's website

There is evidence that clinical staff:

- explain confidentiality, client rights and responsibilities, and roles in a developmentally appropriate way
- discuss any potential medical interventions with the child or young person, and assess their willingness to participate
- take steps to ensure informed consent to any medical treatment, where possible
- obtain consent from a person with legal authority where a child or young person is not able to consent
- understand the specific dynamics of CSA
- address the child or young person's fears relating to possible consequences of disclosure
- are transparent about what information from any client contact will be shared, unless this will compromise safety
- apply knowledge about trauma symptomatology to address challenging behaviours of children and young people who have experienced CSA

There is evidence that counselling staff:

- note protective factors, strengths and resources in the child's family system and community, where appropriate
- carefully explain confidentiality and exceptions to children and young people, and mandatory reporting obligations
- take time to build a relationship with the child or young person
- adapt their practice to make sessions more interesting and engaging
- seek the child or young person's input into their goals for counselling
- involve family/caregivers in counselling where appropriate
- provide children and young people with opportunities to speak to a counsellor in private
- where appropriate, provide psychoeducation for children, young people and family/caregivers about grooming
- work in a systemic way to produce positive outcomes for children and young people
- support the caregivers in accessing their own counselling where necessary
- maintain a focus on the child/young person's safety and wellbeing at all times
- employ techniques from trauma-focused CBT in counselling sessions, where this approach is considered a good match for the needs of the individual child/young person.

3.5 Counselling is informed by the best available evidence

What constitutes ‘best evidence’ and ‘best practice’ can be highly contested. Reliable evidence that can inform the work of counsellors in specialist sexual violence services comes from a range of sources, including quantitative findings, qualitative studies, descriptions of lived experience and practice wisdom (Breckenridge & Hamer, 2014). Some sources of guidance that were identified in the Literature Review for this project that may assist clinicians in working with particular client groups are noted below. Given the dynamic treatment landscape in the field of sexual violence, it is important that counsellors are receptive to new treatment approaches that may improve client outcomes (Kezelman & Stavropoulos, 2019).

3.5.1 Working with complex trauma

Any client who engages with a specialist sexual violence service may have a complex trauma history, but clinicians should be particularly conscious of this possibility when working with survivors of institutional abuse, intra-familial child sexual abuse and children in care/care leavers. In addition to the expectations outlined in these Standards, the clinical practice of counsellors should be informed by the publication:

“Practice guidelines for clinical treatment of complex trauma” (2019) produced by Kezelman, C and Stavropoulos, P, on behalf of Blue Knot Foundation, and available online at <https://www.blueknot.org.au/Resources/Publications/Practice-Guidelines/Practice-Guidelines-2019>

3.5.2 Working with a client with a formal diagnosis of Complex PTSD

A new diagnostic category of Complex Post-Traumatic Stress Disorder was included in the 11th revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-11), produced by the World Health Organization. When working with a client with a formal diagnosis of Complex PTSD, counsellors should be informed by the guidelines below, in addition to these Standards:

“Australian guidelines for the prevention and treatment of acute stress disorder, posttraumatic stress disorder and complex PTSD” (2020) produced by Phoenix Australia, available online at <https://www.phoenixaustralia.org/australian-guidelines-for-ptsd/>

3.5.3 Working with clients who have experienced, or are currently experiencing, Intimate Partner Sexual Violence

Intimate Partner Sexual Violence (IPSV) has become increasingly visible as a form of DFV and a form of sexual violence. Notions of what constitutes “real rape” may hinder the recognition of IPSV amongst victim-survivors, their supporters and organisations. IPSV lies at the intersection of DFV and sexual violence and it is important that organisations taking a collaborative approach in responding to the complex needs of victim-survivors of IPSV, seeking the specialist knowledge of DFV services to manage risk and access resources.

Meeting National Standards

There is evidence that the organisation:	<ul style="list-style-type: none">• identifies IPSV as a form of sexual violence• identifies IPSV as a risk factor for future serious violence, and includes it in risk assessments• recognises the need for a collaborative approach with DFV services when supporting victim-survivors of IPSV
There is evidence that clinical staff:	<ul style="list-style-type: none">• routinely enquire about experiences of IPSV when a history of DFV is disclosed• recognise that IPSV indicates the client is at heightened risk of harm from the person who has perpetrated the sexual violence• understand the unique harms caused by IPSV and the increased risk of suicide• work to counteract the shame that can accompany experiences of IPSV• endeavour to work collaboratively with DFV organisations in cases of ongoing DFV and IPSV

Exceeding National Standards

There is evidence that the organisation:	<ul style="list-style-type: none">• Has established case management models for working collaboratively with DFV organisations in cases where IPSV is present
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3.5.4 Working with victim-survivors of institutional child sexual abuse

Victim-survivors of institutional child sexual abuse have diverse needs, influenced by a range of factors. Like other forms of child sexual abuse and child maltreatment, the impact of child sexual abuse can be profound, producing interconnected issues and difficulties. Service responses should be tailored to the needs of individuals and be responsive to changing needs over the life span. Secondary victims of institutional child sexual abuse (such as partners, children, parents, and siblings) may also need assistance to deal with the impacts on their own wellbeing, as well as to support the victim-survivor.

In addition to the expectations outlined in these Standards, counsellors working with victim-survivors of institutional child sexual abuse should be familiar with Volume 9 of the final report of the Royal Commission into Institutional Responses to Child Sexual Abuse:

“Final Report, Volume 9: Advocacy, support and therapeutic treatment services” available online at https://www.childabuseroyalcommission.gov.au/sites/default/files/final_report_-_volume_9_advocacy_support_and_therapeutic_treatment_services.pdf

3.5.5 Working with children and young people with problematic or harmful sexual behaviours

In many jurisdictions in Australia, specialist sexual violence services are the referral point for children under 10 with problematic or harmful sexual behaviour. Once children reach the age of criminal responsibility (at the age of 10), provision of a therapeutic response can be complicated by criminal justice proceedings commencing. There are significant inconsistencies and gaps in Australia's approach to PHSB (Royal Commission into Institutional Responses to Child Sexual Abuse, 2017a) and organisations and practitioners must ensure they are aware of the arrangements in their jurisdiction.

Meeting National Standards

<p>There is evidence that the organisation:</p>	<ul style="list-style-type: none"> • avoids labelling language such as perpetrator/offender for children with PHSB • recognises that a high proportion of children with PHSB have complex trauma histories • prioritises this client group for service provision • advocates at a systems level for improved service provision for this group • ensures counselling staff have access to clinical, specialist supervision when working with children with PHSB
<p>There is evidence that counselling staff:</p>	<ul style="list-style-type: none"> • have accessed training to gain the knowledge and skills necessary to support this client group and their families/ caregivers • tailor their response depending on the circumstances of the child with PHSB and their family • respond in a manner that is non-punitive and focused on behaviour change • take a multi-agency, collaborative approach • take steps to ensure the safety of children who may have contact with the child with PHSB, both at the service, in their family and in the wider community • involve parents and caregivers in the treatment process, where appropriate • are aware of referral pathways and treatment options in their jurisdiction • choose the language they use carefully, avoiding labels like “perpetrator” or “offender” • recognise the unique challenges for parents/caregivers in responding to the needs of both children in cases of sibling sexual abuse

In addition to the expectations outlined in these Standards, and any relevant legislation or guidelines that apply in their jurisdiction, specialist sexual violence services may find the following publication by Hackett, Branigan and Homes useful:

“Harmful sexual behaviour framework: An evidence-informed operational framework for children and young people displaying harmful sexual behaviours, 2nd edition (2019) available online at <https://www.icmec.org/wp-content/uploads/2019/04/harmful-sexual-behaviour-framework.pdf>

Services should be aware that this framework was produced on behalf of the NSPCC in the UK.

3.5.6 Supporting victim-survivors who have experienced image-based abuse

Clients of specialist sexual violence services may disclose incidents of image-based abuse in a number of ways. They may be existing clients of the service who discover that their assault was filmed in some way. Creating sexual images may have been part of the dynamic of a relationship characterised by IPSV. It is also possible that a client may contact a specialist sexual violence service for the first-time regarding image-based abuse, in the absence of a sexual assault. Organisations and practitioners must stay up to date with the research and law in this dynamic space and be familiar with the role of the eSafety Commissioner.

Meeting National Standards

There is evidence that the organisation:	<ul style="list-style-type: none">• includes image-based abuse in its definition of sexual violence• accepts that psychological harm can be caused by image-based abuse
There is evidence that clinical staff:	<ul style="list-style-type: none">• have undertaken training on the topic of image-based abuse• have a working knowledge of the research related to the dynamics and impacts of image-based abuse• keep up to date with the law relating to image-based abuse in their jurisdiction• are aware of possible remedies for clients affected by this form of sexual violence and are confident discussing these with clients

Exceeding National Standards

There is evidence that the organisation:	<ul style="list-style-type: none">• provides a service to victim-survivors of image-based abuse, regardless of whether they have also been sexually assaulted• collects data on the experiences of image-based abuse amongst clients of the service
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3.5.7 Working with Aboriginal and Torres Strait Islander victim-survivors and their families/communities

One of primary barriers to service provision for Aboriginal and Torres Strait Islander victim-survivors and their families is a misalignment between mainstream health services with Aboriginal and Torres Strait Islander peoples and cultures. The concept of health in Aboriginal and Torres Strait Islander culture is broader than in Western cultures, as it is linked to spirituality, connection to land and culture, and the physical and mental wellbeing of the individual, alongside the social, emotional and cultural wellbeing of the whole community. The health of Aboriginal and Torres Strait Islander people is also influenced by historical, social and political determinants, which is captured in this model of Aboriginal social and emotional wellbeing.

Organisations and practitioners that want to work successfully with Aboriginal and Torres Strait Islander clients must adapt their practice to demonstrate cultural safety. In order to do this, they must build their knowledge of what health and wellbeing means in the context of Aboriginal collectivist cultures, and the resources that exist in the local Aboriginal community that can facilitate recovery and healing. It is also important for organisations and clinicians to be aware of the context of sexual violence within Aboriginal and Torres Strait Islander communities, and potential mistrust of authorities and the system.

Source: Gee, Dudgeon, Schultz, Hart and Kelly, 2013, in Commonwealth of Australia (2017, p. 11)



Meeting National Standards

There is evidence that the organisation:

- has embedded cultural safety in its policies and procedures
- supports the ongoing education of its clinical staff to build knowledge in the organisation about Aboriginal and Torres Strait Islander health and wellbeing, and cultural healing practices
- appreciates the additional time practitioners may need to engage with Aboriginal and Torres Strait Islander clients and their families and adjusts the workload of practitioners accordingly
- allows for a longer period of intervention and engagement, to facilitate the worker building trust with the worker and the service
- is sought out by Aboriginal and Torres Strait Islander victim-survivors

There is evidence that clinical staff:

- are aware of traditional and contemporary Aboriginal healing practices and can facilitate access to these practices in the local Aboriginal community
- provide culturally and clinically appropriate specialist sexual violence support
- work in a holistic way, recognising the importance of engaging with families, particularly when supporting children and young people
- are conscious of the potential for caregivers of children/ young people to have their own histories of sexual violence, and support them (or provide appropriate referrals) accordingly
- seek to work in genuine partnership with victim-survivors, allowing them, as far as is possible, to determine their own treatment
- have an awareness of concepts such as yarning (Guthrie & Lovett, 2020) and dadirri (deep listening) (Ungunmerr, 1988), and adapt their usual style of assessment and counselling accordingly when working with Aboriginal and Torres Strait Islander victim-survivors and families

Exceeding National Standards

There is evidence that the organisation:

- adopts a cultural brokerage model to facilitate engagement with Aboriginal and Torres Strait Islander victim-survivors and families

3.6 Therapeutic/support groups

Therapeutic groups can be of benefit to clients who have experienced sexual assault. While research is limited in Australia, there is some international evidence to suggest that therapeutic groups have a positive effect on the relationships, social lives and self-esteem of victim-survivors, particularly victim-survivors of child sexual abuse. Practice wisdom supports this research; well-designed therapeutic groups, delivered by skilled practitioners, can be a highly effective arm of the clinical practice of specialist sexual violence services.

Meeting National Standards

There is evidence that the organisation:

- provides group work programs informed by trauma theory and evidenced to be beneficial to participants
- employs qualified sexual assault counsellors with group facilitation skills to facilitate the groups
- ensures the content of group work programs is consistent with the principles of adult education
- collects evaluations from participants and collates the data
- provides clinical oversight of group work programs
- ensures therapeutic/support groups offered to children and young people are age and developmentally appropriate, and the safety of child participants is paramount

There is evidence that clinical staff:

- have sufficient intake and assessment procedures in place to ensure that participation in the group is appropriate for the client's needs
- have informed group participants of their rights and responsibilities, including confidentiality, consent, terms of service
- have obtained written consent to participate from each participant
- have procedures in place to follow up on the safety and wellbeing of group participants during and between group sessions
- invites feedback from participants regarding group processes and outcomes
- have guidelines in place, which have been discussed with clients, to manage confidentiality and consultation between practitioners, where a client is participating in counselling and group work simultaneously
- critically reflect on group work experiences in supervision

Exceeding National Standards

There is evidence that the organisation:

- offers groups to identified groups in the community, facilitated (where possible) by a clinician who belongs to that particular community group, e.g., a group for lesbian women who are survivors of child sexual abuse, facilitated by a clinician who identifies as lesbian

3.7 Support is offered to those who support the victim-survivor

Specialist sexual violence services recognise the crisis that a disclosure of sexual violence can provoke for significant people in the lives of victim-survivors. This is particularly the case when children and young people disclose intrafamilial sexual abuse. Those around the victim-survivor will have their own reactions to the disclosure and may need counselling to manage their responses, so that they can support the victim-survivor. If the support person has their own history of child sexual abuse, the disclosure may present even more difficult challenges.

Meeting National Standards

There is evidence that the organisation:

- regards the provision of support to those who support the victim-survivor as core business, particularly in cases of CSA
- endeavours to avoid conflicts of interest by allocating the parent/caregiver to another counsellor within the service, in situations where the parent-caregiver needs a significant level of support

There is evidence that clinical staff:

- routinely offer assistance to the caregivers of children and young people who present to the service having experienced child sexual abuse. Siblings may also benefit from the opportunity to speak to clinical staff. In cases of intrafamilial CSA, the extended family may require support
- with the consent of the individual, provide warm referrals to a suitable service when the organisation is not adequately resourced to provide counselling to parents/caregivers and significant others

Exceeding National Standards

There is evidence that the organisation:

- facilitates support groups for parents/caregivers of children and young people who have experienced CSA

3.8 Maintaining appropriate boundaries

For clinical work to be safe and effective, staff must ensure that they have appropriate boundaries. Determining what is appropriate with different clients depends on a range of factors, and clinicians must use their professional judgement, draw on practice wisdom, look to sources of guidance such as their Code of Ethics, and consult their clinical supervisor. Maintaining boundaries can be more difficult in rural or remote settings and for workers who are active members of minority community groups.

Meeting National Standards

There is evidence that the organisation:

- provides guidance via the policy and procedure manual as to appropriate boundaries with clients
- encourages critical reflection on boundaries in supervision
- addresses boundary violations effectively, carefully considering the potential impact on the victim as part of the decision-making process
- advise victim-survivors of external complaint options in situations where serious boundary violations have potentially occurred

There is evidence that clinical staff:

- understand that professional boundaries may need to be flexible, especially when working with clients with complex trauma histories
- recognise that clients may find professional boundaries challenging, and work with clients to see boundaries as supportive rather than punitive
- recognise the connections between maintaining appropriate boundaries and self-care
- adhere to the guidance of their professional association regarding friendships and sexual relationships with former clients
- seek supervision when they are concerned about their professional boundaries
- take additional steps to protect the privacy of their social media accounts



STANDARD 4

Valuing Advocacy, Collaboration, and Community Engagement

Advocacy

Advocacy is a crucial part of service delivery which reflects the foundational frameworks of specialist sexual violence services, including feminist understandings of sexual violence, intersectionality, anti-oppressive practice and social justice. Advocacy is a core component of good collaborative practice that recognises the relationship between sexual violence and trauma, as services may need to engage across service systems on behalf of the victim-survivor.

Services should be aware of the difference between and importance of systems and individual advocacy to meet the needs of victim-survivors:

- **Individual advocacy** aims to meet the specific needs of an individual victim-survivor and is an essential component of direct service delivery. This can occur

on behalf of the victim-survivor, with their consent, or in partnership with them. Examples of individual advocacy include negotiating for access to mental health services, housing and legal support.

- **Systems advocacy** aims to influence and change broader structures, including policy and practice systems, for the benefit of a larger group of people. Examples of system advocacy include raising awareness of the issue of sexual violence in the media, advocating for funding and influencing law reform.

Collaboration

In recent years, there has been a push for greater collaboration and integration



of services which have historically been siloed, fragmented, and disconnected (NSW Ministry of Health, 2019b). The sexual violence service system can be experienced as complex and confusing, and victim-survivors have emphasised the importance of having access to holistic services that are connected to one another and respond to their intersecting needs (Stefiandou et al. 2020). Coordinated and integrated service delivery is now acknowledged as best practice when responding to the complex needs of victim-survivors.

Sexual violence is associated with a range of immediate and long-term negative health consequences, including depression and anxiety, and alcohol and alcohol and other drug misuse (ANROWS 2020; Breckenridge et al. 2019; Stefanidou et al. 2020). As such, services must be prepared to proactively engage and partner with other agencies such as DFV, mental health, alcohol and other drug services and child protection. Multiple interventions from a variety of services may be needed to respond to the complex intersections between sexual violence, trauma and mental health.

Current evidence suggests that effective service integration is based on:

- relationship building within and between services (Hegarty et al. 2017)
- integrated referral pathways and coordinated care (Hegarty et al. 2017)
- accessibility, including services that provide 24/7 access and multi-lingual

services (Stefiandou et al. 2020)

- a shared understanding of roles and language (Hegarty et al. 2017).

Services must also be aware of the barriers to creating integrated responses to sexual violence, including a lack of time and resources, a tendency for services to focus solely on their 'core business' and a lack of knowledge of referral pathways (ANROWS 2020). Victim-survivors should also be asked to provide consent for their information to be shared with other organisations.

Community engagement

It is important that sexual violence services adapt their practice and engagement strategies to reflect the needs of the local community, as a thorough understanding of the community in which the service operates is an essential first step in improving access. Building relationships in the local community takes time, and services need to be adequately resourced in order to do community engagement work. Services should look for opportunities to build capacity in the wider community.

Engaging with local Aboriginal and Torres Strait Islander communities creates opportunities for mainstream services to increase cultural safety within the organisation and facilitate client access to community resources that can assist Aboriginal and Torres Strait Islander

individuals and families to heal from the impacts of sexual violence and intergenerational trauma. Many Aboriginal and Torres Strait Islander communities have members that do valuable work responding to sexual violence, even if they are not formally trained as sexual violence specialists. Through collaborating with these individuals, outcomes for Aboriginal and Torres Strait Islander clients and their families/communities may be improved. Genuine engagement and partnership demonstrates respect for Aboriginal and Torres Strait Islander voices and culture and is a step towards building a better, stronger nation.

4.1 Undertaking both individual and systemic advocacy

Any advocacy undertaken on behalf of an individual requires the consent of the client. Staff must ensure that when engaging in advocacy on the client's behalf, they do not share any information the client wishes to remain with the sexual violence service.

Meeting National Standards

There is evidence that the organisation:

- advocates for systemic reforms and social change aimed at both preventing and improving outcomes for victim-survivors of sexual violence
- commits resources to systems and individual/client advocacy
- has policies and procedures in place which support practitioners in their advocacy work
- provides practitioners with opportunities for professional development in advocacy
- can quantify and describe its advocacy work, both at the individual and systemic level
- supports practitioners putting counselling work on hold and taking on primarily an advocacy role when this is more appropriate (e.g., in the case of acute mental ill-health) and the client is able to resume counselling as soon as this is clinically indicated

There is evidence that clinical staff:

- take on an advocacy role, with the consent of their clients, or alternatively support clients to advocate for themselves, where appropriate, and in age-appropriate ways for children and young people
- obtain written consent from the client to engage in advocacy work where practicable
- have knowledge of external advocacy services that may be of benefit to client groups

Exceeding National Standards

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|---|--|
| There is evidence that the organisation: | <ul style="list-style-type: none"> • collects data, and reports annually, on its advocacy work • takes opportunities to contribute to the understanding of the trauma impacts of sexual assault, both amongst other professionals (such as medical, police, legal profession, child protection) and the wider community, and other relevant issues such as prevention of sexual violence and appropriately responding to victims of sexual violence. |
|---|--|

4.2 Enhancing interagency practice

Research has demonstrated that the service system surrounding victim-survivors of sexual violence can be experienced as complex, confusing, and hard to navigate. Agencies working to support victim-survivors and their supporters must endeavour to work better together to improve the experiences of, and outcomes for victim-survivors.

Meeting National Standards

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|---|---|
| There is evidence that the organisation: | <ul style="list-style-type: none"> • recognises that strong interagency relationships improve outcomes for victim-survivors • develops and ensures the currency of interagency guidelines with relevant service partners • regards staff attending and participating in interagency forums or similar events core business • proactively engages with interagency partners following situations where interagency practice has broken down to avoid future issues • communicates any changes to interagency guidelines to all staff in a timely fashion • supports early intervention, particularly when working with children and young people |
| There is evidence that all staff: | <ul style="list-style-type: none"> • are familiar with the content of current interagency guidelines • work to foster positive, professional relationships with staff from allied agencies |
| There is evidence that clinical staff: | <ul style="list-style-type: none"> • consider the needs of interagency partners when making case decisions, although the needs of the victim-survivor are always the paramount concern • attend interagency events • practice in accordance with the principles of early intervention, particularly when working with children and young people and their families/caregivers |

Exceeding National Standards

There is evidence that the organisation:	<ul style="list-style-type: none">• seeks out or creates opportunities for shared training with allied agencies which provides a strong foundation for interagency practice
There is evidence that clinical staff:	<ul style="list-style-type: none">• routinely critically reflect on their interagency practice in clinical supervision

4.3 Creating new opportunities for collaborative practice

Research has indicated that the needs of victim-survivors of sexual violence, particularly those with complex trauma histories, are often complex and multifaceted. For historical reasons, many services are “siloed”, meaning the care delivered can be fragmented. Victim-survivors may have difficulty working with multiple agencies and experience secondary (systems created) trauma due to inconsistent and uncoordinated service delivery. Many have indicated that they would prefer more holistic and “joined-up” services and that this would have positive impacts on their health and wellbeing, which is supported by research. In circumstances where it is not possible or desirable to fully integrate services, collaborative practice, whilst challenging, is essential in responding to sexual violence.

Meeting National Standards

There is evidence that the organisation:	<ul style="list-style-type: none">• recognises that collaborative practice is fundamental to service delivery in the field of sexual violence• is proactive in seeking out agencies that it could partner with, in related fields such as DFV, child protection, alcohol and other drug services, housing, women’s health and community health centres, schools, Universities and higher education institutions, inpatient psychiatric wards, probation and parole etc.• supports a flexible approach to collaborative work in the absence of an established model, but provides clinical oversight to practitioners via supervision• explains to funders that collaborative work is time and resource intensive, and this must be reflected in the service’s budget.
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There is evidence that clinical staff:

- with the consent of the victim-survivor, approach staff at other agencies that are engaged with the victim-survivor, to explore ways to provide more holistic, joined up services
- where appropriate, record in writing how services will support mutual clients, clearly delineating roles, and responsibilities, as well as what information needs to be shared, and how it will be communicated. Clinical staff ensure that both the victim-survivor and staff in allied agencies agree with the arrangements.

Exceeding National Standards**There is evidence that the organisation:**

- has developed protocols for working with allied agencies and has an established practice of joint work with mutual clients engaged with a range of agencies
- seeks feedback from shared clients about their experiences of agencies working collaboratively
- has developed models for collaborative work and evaluates the effectiveness of the models

4.4 Engaging with local communities

The organisation sees itself as a part of the local community and establishes connections with and serves the range of communities that are part of the local community.

Meeting National Standards

There is evidence that the organisation:

- has comprehensive knowledge of local communities and this knowledge informs its strategic and service planning
- has a strategy for engaging with marginalised and disadvantaged members of the communities it supports
- offers training and education programs for community groups, and aims to promote community awareness of sexual violence and its personal and social consequences
- evaluates any community education programs it delivers
- updates community education programs based on feedback, specific community needs and to reflect developments in research and clinical practice
- ensures that engagement, education, and prevention programs with local communities are culturally appropriate and responsive to community input and feedback
- seeks to genuinely partner with local communities, respecting their point of view and lived experience, and build a more nuanced understanding of possible meanings of sexual violence in diverse communities
- recognises that there is diversity within marginalised communities and, where possible, seeks the input of multiple members/organisations of these communities
- utilises culturally sensitive marketing for its services, and provides written information in a range of community languages, reflecting the diversity of the communities in which it is situated
- monitor service delivery data to ascertain whether an equitable service is being delivered to the communities it intends to serve

There is evidence that clinical staff:

- are informed about past trauma experiences common to certain groups in the community (for e.g., colonisation, refugee experiences and histories of institutional abuse)
- can conceptualise recent traumatic experiences in the context of past experiences of trauma as well as intergenerational trauma
- are sensitive to client privacy in community settings
- offer support whenever they conduct community education in the event that a participant is triggered by the content

Exceeding National Standards

There is evidence that the organisation:

- advocates for additional services and resources for groups in the community who are currently unable to access services and/or where appropriate services are not available

There is evidence that clinical staff:

- modify practice (with clinical oversight) to deliver services in innovative ways such as outreach, co-delivery, and group work programs targeted at particular client groups where they are aware of barriers to diverse and marginalised community groups accessing services

4.5 Capacity building

Due to the prevalence of sexual violence in the community, many people who have experienced sexual violence are engaged with a range of organisations and health services in the community. Specialist sexual violence services play a key role in developing the capacity of government and non-government agencies and services to better respond to people who have been affected by sexual violence.

Meeting National Standards

There is evidence that the organisation:

- includes the development and delivery of community and professional education programs in its service plan
- shares its specialist knowledge to other organisations via one-to-one consultation to support the delivery of appropriate and effective services to victim-survivors of sexual assault
- collaborates with other organisations where that organisation has the relationship or mandate to work with the victim-survivor but the specialist sexual violence service has knowledge and expertise that could contribute to more effective work with that victim-survivor
- has a mechanism for capturing data related to consultations and training provided
- evaluates training programs and revises content based on feedback from participants

There is evidence that clinical staff:

- draw on their expertise to provide recommendations and/or suggestions when consulted by another organisation
- adhere to normal reporting requirements if they have safety concerns or reporting obligations based on the information received
- refer on to other practitioners or organisations if consulted about an area that is outside their area of expertise
- recognise when staff from other services are triggered by their contact with a victim-survivor of sexual violence and either offer or recommend debriefing/defusing



STANDARD 5

Valuing Staff



Organisations that are trauma-informed should value staff health and wellbeing and recognise the impact that working with victim-survivors of sexual violence can have on the personal and professional life of staff. The potential negative effects of working with trauma are well established but many practitioners also report personal positive impacts from the work, including compassion satisfaction, and post-traumatic growth (Crivatu, Horvath, & Massey, 2021).

Practitioners may experience vicarious trauma as a result of responding to sexual violence. Vicarious trauma is a workplace health and safety issue, and it is the responsibility of both the organisation and employees to respond to this. The nature and degree of the impacts of working with victim-survivors of sexual violence is dependent upon both personal factors and workplace factors (1800Respect, 2020), with workplace factors appearing to have a greater influence than personal factors (Crivatu et al., 2021). Workplace factors include:

- workload
- perceived organisational support and guidance
- competing demands
- level of responsibility
- caseload mix
- challenging work conditions
- opportunities to debrief between clients

Individual factors include:

- adaptive coping strategies
- current life circumstances
- work style
- social support
- personal history – past experience of similar trauma (1800Respect, 2020; Crivatu et al., 2021).

Providing employees with regular supervision, opportunities for debriefing and defusing, and peer support can help to mitigate the risks of vicarious trauma.

As Crivatu et al note “...working with this



highly traumatized population requires skill, resilience, coping strategies and support” (2021, p. 11). It is essential that organisations support employees to address the impacts of working with victim-survivors of sexual violence for their own wellbeing, but also as it impacts on the quality of their work and in turn, the wellbeing of their clients (Crivatu et al., 2021; Monash Gender and Family Violence Prevention Centre, Domestic Violence Victoria, & Domestic Violence Resource Centre Victoria, 2021).

Organisations who do not actively seek to manage the negative impacts of working with victim-survivors of trauma will face issues around absenteeism and high staff turnover, which in turn impacts on service provision. Organisations must demonstrate that they value their staff who do “... what could be considered, the hardest work in the caring profession” (Crivatu et al., 2021, p. 11). In times of social disruption and crisis, such as during a global pandemic, the risk of vicarious trauma for those in the caring profession is amplified, as work practices must adapt to changed circumstances and clients experience even greater hardship. Organisations must be proactive around the wellbeing of staff, taking tangible steps to prioritise and plan for the wellbeing of workers before, during and after such events (Monash Gender and Family Violence Prevention Centre et al., 2021).

The delivery of specialist sexual violence services requires ongoing training and education to assist all employees in

maintaining competence in their role. Given the dynamic treatment landscape in the field of sexual violence and the complexity of skills required, ongoing professional development is needed to ensure practitioners are informed regarding new treatment approaches that may improve client outcomes (Kezelman and Stavropoulos, 2019).

As highlighted in Standard 1, Valuing access for all clients, specialist sexual violence services should actively seek to recruit staff of diverse backgrounds. The organisational culture must support respect and robust discussion amongst staff, and facilitate opportunities for staff to learn from one another. Differences in opinion related to religion, sexuality, ability, age and gender and culture should be recognised as a strength of the service, and harnessed as a mechanism to enrich clinical practice and client access.

Organisations should actively seek the input of Aboriginal and Torres Strait Islander employees, in order to drive culturally appropriate and culturally informed services. Recognising that many workers in this field have their own experiences of sexual violence, and may be working within mainstream services whose approach is not completely compatible with Aboriginal and Torres Strait Islander cultures and practices, organisations must be particularly mindful of the health and wellbeing of Aboriginal and Torres Strait Islander employees.

5.1 Creating a supportive workplace and a functional team

Working in sexual violence, and hearing people's stories of violence and trauma, impacts upon staff. It is essential that the team feel well supported, as this is not only protective for staff, but also ensures that victim-survivors receive higher quality services, producing better clinical outcomes. It is also important to foster positive dynamics in the team.

Meeting National Standards

There is evidence that the organisation:

- acknowledges that all staff working in a specialist sexual violence service may be impacted by stories of trauma, abuse, and disadvantage that they encounter in their role
- has a comprehensive framework with multi-pronged strategies in place to monitor and manage vicarious trauma
- has comprehensive and consistent policies in place to address workplace conflict, staff disputes, grievances, and complaints
- recognises and encourages staff to identify the beneficial effects of working with people who have experienced trauma
- supports rituals in the workplace that help staff to maintain positive working relationships, for example, a weekly team lunch or in-house yoga class
- promotes staff engaging in acceptable self-care activities whilst at work
- recognises that sexual relationships between staff members can significantly impact on the dynamics in a workplace, and therefore have policies and procedures in place to manage sexual relationships between staff
- has policies in place that discourage the development of sexual relationships between staff and line managers, clinical supervisors, board members or equivalent

There is evidence that clinical staff:

- are encouraged and supported to maintain work-life balance
- disclose any sexual relationship that develops with a staff member to their line manager and/or clinical supervisor

Exceeding National Standards

There is evidence that the organisation:

- provides access to an employees' assistance program to all employees regardless of employment status (e.g., full time as well as part time, permanent and casual/contract)
- has provided training to managers and supervisors to facilitate them supporting and assisting staff affected by their own personal experiences of sexual violence
- supports and encourages staff to have opportunities to build their relationships outside the work environment but in work time – e.g., annual away day, team building day, etc

5.2 Recognising and responding to the needs of administrative, reception and intake workers

It is important to recognise that administrative and reception staff, as well as staff who are first points of contact for intake calls, can also be exposed to traumatic material. Workplaces must take steps to safeguard their wellbeing.

Meeting National Standards

There is evidence that the organisation:

- recognises that administrative, reception and intake workers (who are not also part of the clinical team) may be impacted by the work
- provides orientation relating to sexual violence, sexual violence services, intake policies and procedures, cultural competency, containment and de-escalation and emergency procedures before staff commence in their role
- seeks to minimise the exposure of non-clinical staff have to clinical discussions and sensitive/distressing material
- has systems in place to support the physical and mental wellbeing of administrative, reception and intake workers
- routinely undertakes debriefing/defusing in the case of a critical incident.

There is evidence that all staff:

- have a period of orientation to any new role and undertake mandatory training

Exceeding National Standards

There is evidence that the organisation:

- offers a debrief/defuse any staff member who have been first point of contact for an intake for the specialist sexual violence service. This may involve switchboard staff or emergency department staff in large hospitals
- provides access to an employees' assistance program to all employees regardless of employment status (e.g., full time as well as part time, permanent and casual/contract)

5.3 Recognising and responding to the learning and development needs of clinical staff

Access to ongoing professional development is required to assist all workers maintain competency and confidence in their role. Clinical staff employed by a sexual violence service require a broad range of knowledge, skills, and experience.

Meeting National Standards

There is evidence that the organisation:

- allocates resources in its annual budget to the professional development and training of staff to assist in maintaining a competent and skilled workforce
- can demonstrate an equitable approach to professional development for all employees
- assists staff to identify professional development needs through clinical supervision and and/or via input from the line manager
- has systems in place to document and log participation in professional development activities
- highlights professional development opportunities to staff in staff meetings and clinical supervision

There is evidence that clinical staff:

- have a professional development plan outlining goals and strategies relevant to career aspirations and skill needs, prepared in consultation with their clinical supervisor and/or line manager, which is reviewed annually
- undertake a period of orientation when coming to any new role, participate in mandatory training and maintain professional development activities as required by their professional association

Exceeding National Standards

There is evidence that the organisation:

- support staff to undertake further education aligned with their role as part of their work hours, or provide the option of study leave, particularly where this results in a qualification such as a diploma, or degree
- highlight further education, scholarship and secondment opportunities to staff
- secures access to online journals for staff so that they can view recent research articles on relevant topics
- has a system in place whereby staff share knowledge gained through any training attended with the rest of the team.

5.4 Recognising and responding to the supervision and debriefing/defusing needs of clinical staff

Clinical staff, who provide direct services to people impacted by trauma, require support to manage the immediate, daily, and ongoing impacts of trauma work. They also need opportunities to improve on clinical practice and identify gaps or weaknesses in knowledge and practice. Supervision and debriefing/defusing are important measures which allow organisations to respond to the needs of clinical staff.

Meeting National Standards

There is evidence that the organisation:

- recognises that supervision, debriefing/defusing, and peer support form part of a safe system of work in specialist sexual violence services
- ensures that all clinical staff members have access to individual supervision and debriefing/defusing, including medical staff, any assistants or chaperones required for medical examinations and counselling staff that work only on the after-hours roster
- funds clinical supervision and staff attend in paid work time
- supports staff to critically reflect upon their interventions with clients and consider the personal impact of the work upon them are core aspects of effective clinical supervision
- secures qualified practitioners who have undertaken additional training in clinical supervision to provide clinical supervision to staff. The practitioner providing supervision does not need to be from the same professional background as the staff member
- requires that a Supervision Agreement be discussed at the commencement of the supervisory relationship
- advises staff members that supervision provides for ‘limited confidentiality’ – the specific content of the supervision session remains confidential, unless there are ethical or quality concerns about the practitioner or their practice
- matches the frequency and duration of clinical supervision to the needs of the staff member (e.g., their experience, case load, complexity of cases, job-related stress levels) but supervision occurs at least monthly
- supports clinical staff members debriefing/defusing and accessing formal or informal peer support/supervision in addition to clinical supervision
- routinely undertakes debriefing/defusing in the case of a critical incident

Exceeding National Standards

There is evidence that the organisation:

- supports and pays for clinical staff to access external supervision in circumstances where the needs of a client of the service exceed the expertise of the counsellor and the clinical supervisor, and where referral on to another practitioner or service is not appropriate
- provides access to an employee assistance program to all employees regardless of employment status (e.g., full time as well as part time, permanent and casual/contract)

5.5 Considerations for counselling team members

Supervisors and line managers should consider additional considerations regarding the work practices of counselling staff. These additional considerations arise due to the impact and nature of an ongoing therapeutic relationship, and empathetic engagement with the emotions associated with experiences of sexual violence and other trauma.

Meeting National Standards

There is evidence that the organisation:

- is mindful of the number and complexity of cases allocated to each counsellor, and in deciding how to allocate cases, takes into consideration a range of relevant matters, including but not limited to the complexity of each allocated victim-survivor's needs, advocacy required, travel time, coordination required with other services, and other responsibilities that form part of the counsellor's role
- ensures that, as far as is practicable, the clinical needs of the victim-survivor match the skill level of the counsellor
- ensures that all counsellors have an appropriate case load mix and makes every effort to incorporate diversity into work tasks
- supports counsellors taking adequate time between counselling sessions to write up case notes, to prepare for upcoming sessions, to undertake advocacy work and to take breaks
- provides a comfortable working environment with staff amenities, whereby staff have space to take breaks away from their desk and clinical areas
- has policies and procedures in place to manage client allocation, case load, appointment load and case load mix.

5.6 Line management support

In some organisations, clinical supervision and line management may be provided by different people. The organisation must give careful consideration as to lines of accountability to ensure that the arrangements are clear to staff and support the provision of good quality services.

Meeting National Standards

There is evidence that the organisation:

- ensures that staff have regular contact with their line manager and receive adequate line management support
- has established a quality assurance connection between clinical supervision and line management
- has developed clear lines of accountability and in the event that a staff member advises that they have been given conflicting advice or instructions, the line manager and clinical supervisor resolve any conflict and provide clear instructions to the staff member

5.7 Staff input into planning, evaluation, service design and delivery

Planning and evaluation assists services to achieve a high standard of professionalism. The organisation should have a participative and reflective approach to planning, evaluation, service design and service delivery.

Meeting National Standards

There is evidence that the organisation:

- demonstrates its respect for the expertise and practice wisdom of its staff by consulting with staff when planning, when considering changes to service design or delivery and in evaluation processes
- ensures that it complies with WHS law by consulting with all staff around changes to service delivery that may affect the health and safety of workers

Exceeding National Standards

There is evidence that the organisation:

- recruits a staff representative for board meetings or equivalent, where this is appropriate given the structure of the organisation

5.8 Clear communication channels

Clear communication channels are essential to ensure that the organisation runs smoothly. When an organisation institutes clear systems for information flow and two-way communication, it maintains an effective and positive work environment and promotes good practice.

Meeting National Standards

There is evidence that the organisation:

- has transparent communication systems
- endeavours to have two-way communication with staff, and the views of staff are sought, respected and acted upon where possible
- attempts to resolve workplace disputes and conflict informally in the first instance
- has comprehensive and consistent policies and practices to address workplace conflict, staff disputes, grievances, and complaints
- supports staff to use these grievance processes where informal mechanisms have failed
- endeavours to resolve workplace conflict as quickly and as amicably as possible, to preserve professional relationships and minimise workplace conflict and stress

5.9 Ensuring staff safety

The safety and wellbeing of staff is an essential consideration in any workplace, but there are particular risks associated with sexual violence services. Organisations and managers must consider both the physical and psychological safety of staff and have policies and procedures in place to minimise risk but also respond to incidents that may arise.

Meeting National Standards

There is evidence that the organisation:

- has work health and safety policies compliant with the relevant legislation
- has policies and procedures in place to support staff to effectively manage potentially volatile or aggressive clients
- ensures all staff have undertaken training in de-escalation procedures and know what to do in a range of potential emergency situations
- has installed adequate security systems in the building and work environment to protect the safety of clients and staff members
- has policies and procedures in place to manage, where relevant, risks associated with night work, shift work, lone workers and distance driving for clinical work
- has protocols in place to manage risk for staff travelling out of the office
- stores the personal contact details and home addresses of staff in a secure location
- does not provide the contact details of staff to any individuals or organisations without the express permission of the staff member
- provides support to any staff whose security has been compromised, including situations where a staff member or their associates have been contacted or harassed in virtual spaces

There is evidence that all staff:

- adhere to procedures relating to travel outside of the office, including informing other staff of the locations of visits and expected times of return
- take steps to protect their identity and personal details when using social media

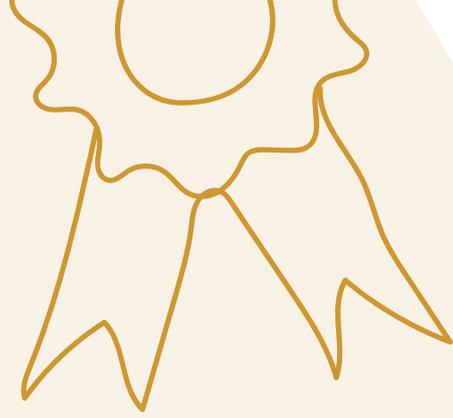
Exceeding National Standards

There is evidence that the organisation:

- has installed alternate entry/exit points from the building which can be used by staff and vulnerable clients



STANDARD 6



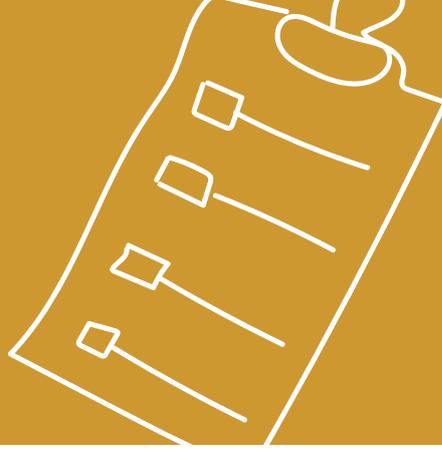
Valuing A Stable Organisation, Good Governance and Effective Systems

Good governance requires organisations to have systems and processes for its direction, control, decision-making and accountability. Services must be aware of their legal responsibilities, particularly in relation to child protection, confidentiality, and record-keeping, and this should be integrated into existing organisational policies and guidelines. Organisational leaders are responsible for establishing and maintaining a stable organisation and effective system through transparent communication and decision-making, monitoring standards, being risk aware and responsive, and ensuring the organisation is financially efficient.

To guide planning and evaluation, organisations should collect data relating to service provision and the demographics

of clients and should seek staff, client and stakeholder input when undertaking these processes.

Confidentiality is fundamental to the provision of sexual violence services and should be assured in all aspects of service provision. Services should have policies in place to protect confidentiality and ensure they communicate with clients about any legal obligations to share information. Alternative methods of service delivery, such as online chat and telephone counselling, are becoming increasingly common and may pose unique risks to privacy and confidentiality (NSW Ministry of Health, 2020).



Another aspect of good governance that can be overlooked is ensuring the participation of victim-survivors from all backgrounds in decision making about programs and service delivery. Organisations must critically evaluate whether systems and practices are adapted to accommodate clients from diverse backgrounds, or alternatively, whether clients are expected to adapt to the organisation's preferred ways of working.

Ultimately, a stable organisation is crucial for the therapeutic relationship between victim-survivors and staff, as it creates reliability and predictability which is necessary for a trauma-informed approach. Promoting trust between staff, management and victim-survivors can also ensure staff wellbeing and retention, reduced costs related to rehiring and retraining and overall financial efficiency.

6.1 Purpose and Vision

The organisation has a clear sense of its purpose as a specialist sexual violence service and this is captured in a vision statement (or equivalent). The values in this statement reflect the philosophical underpinnings of the sector, namely: feminist understandings of sexual violence, intersectionality, the trauma model of recovery, social justice, victim's rights and client-centred care.

Meeting National Standards

There is evidence that the organisation:	<ul style="list-style-type: none">• has developed the vision statement with input from staff members and management• has ensured its vision statement is accessible to all staff members, clients and the community• manages funds for the benefit of service users• directs funds towards primary prevention, advocacy, community awareness and engagement, as well as clinical services• as a whole, particularly leaders of the organisation, champion the organisation's purpose and vision.
There is evidence that all staff:	<ul style="list-style-type: none">• demonstrate an understanding of the vision of the organisation and practice in accordance with this

Exceeding National Standards

There is evidence that the organisation:	<ul style="list-style-type: none">• reviews the vision statement every two years• develops and reviews the vision statement with input from client representative groups and other community partners/stakeholders
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6.2 Governance and Management

The organisation's structure and management systems are designed to deliver the stated purpose of the organisation and foster a supportive, respectful and responsive organisation for employees and clients.

Meeting National Standards

There is evidence that the organisation:

- has sufficient policies and practices in place to ensure good governance
- is managing risk at all levels including governance, human resource functions, financial management, IT systems, work health and safety, clinical services
- is responsive and compliant with relevant legislation, regulations and codes of professional practice
- has clearly articulated lines of accountability and delegations of authority in place
- has established mechanisms for line management supervision
- is accountable to clients and funding bodies

Exceeding National Standards

There is evidence that the organisation:

- proactively supports clients to meaningfully contribute to the governance of the service through processes such as strategic planning, service review and designated roles on boards/in committees

6.3 Service planning and evaluation

It is important for services to plan in order to ensure that they can meet the needs of clients and can maximising resources appropriately. Evaluation assists services to achieve a high standard of professionalism, to deliver quality services, and demonstrate respect for the input of clients.

Meeting National Standards

There is evidence that the organisation:

- has established a clear link between the organisation's purpose and values and its planning framework
- has clearly articulated goals with related objectives, strategies, time frames, outcome indicators and evaluation methods in its plans (strategic, business etc)
- actively involves all staff in planning and evaluation processes
- reviews plans annually
- collects and analyses outcome data to understand whether it is making a positive impact on the lives of clients and look for ways to improve service delivery

There is evidence that counselling staff:

- monitor client progress against goals and positive outcomes that the client has identified

Exceeding National Standards

There is evidence that the organisation:

- uses systematic processes to collect and analyse feedback from clients, staff and partner agencies to inform planning and improve service delivery. A range of options are available to encourage feedback, including face to face, written and online
- seeks input from client representative groups and other key stakeholders in its planning and evaluation
- seeks feedback from clients who have decided not to continue to engage with the service.

6.4 Privacy, confidentiality, and exceptions

The organisation has a comprehensive plan for protecting the confidentiality of client information and is transparent about any obligations to share information.

Meeting National Standards

There is evidence that the organisation:

- is aware of, and has policies consistent with their state or territory's health records and information/privacy legislation, as well as mandatory reporting and first disclosure obligations
- has policies and procedures in place to protect client information, including procedures for dealing with breaches of client information
- provides written and verbal information to all clients regarding confidentiality as applicable to them. This information explicitly identifies exceptions to confidentiality
- has taken steps to ensure that its policies and practices around information sharing are consistent with the **National Privacy Act 1988**, any state/territory health records legislation, and state/territory child protection related legislation
- has policies and procedures in place for managing client requests to access their own file

There is evidence that all staff:

- are aware of the policies and procedures and how they apply to their roles
- inform clients and visitors of the organisation's privacy and confidentiality policy
- inform clients of the reasons for requesting their personal details, how they are stored and how their information may be used

Exceeding National Standards**There is evidence that the organisation:**

- seek to obtain written client consent prior to consulting with another agency when coordinating care, making referrals or seeking services of another agency. If consent is verbal, this will be documented
- inform clients of any instance of disclosure of their information, unless doing so would threaten client safety or the safety of a third party (for example a child)
- ask clients about their preferred method of contact (phone, email, text, mail) and any other conditions of contact the client considers necessary to protect their safety and privacy.
- make contact with another service to facilitate a warm referral, in situations where this is warranted, and the client has consented

6.5 Child protection

Organisations may have child protection concerns relating to the children of adult clients, or siblings, friends, or relatives of child clients. Child protection concerns may arise out of therapeutic work with children and young people, who make further disclosures of child sexual abuse or disclose other forms of abuse they have witnessed or experienced. Furthermore, child protection issues may arise when a client identifies that a person who perpetrates sexual violence has ongoing contact with children – either through family or social contacts, or due to paid/voluntary work.

Meeting National Standards

There is evidence that the organisation:	<ul style="list-style-type: none">• has policies and procedures consistent with child protection laws and regulations in its state/territory, including compliance with working with children checks• has policies and procedures consistent with any child protection interagency guidelines in its state/territory• has policies reflecting the National Principles for Child Safe Organisations• ensures networking and referral links are maintained with a broad range of agencies that may be able to support clients and families to establish safety, stability, and functional family life• has privacy and confidentiality policies which explicitly address child protection exclusions
There is evidence that staff:	<ul style="list-style-type: none">• understand their mandatory reporting obligations, and are able to explain mandatory reporting obligations to all clients, particularly children and young people, in a clear and appropriate manner• document child protection activities in client files

Exceeding National Standards

There is evidence that the organisation:	<ul style="list-style-type: none">• ensures that matters of child protection, confidentiality, and consent in the context of maintaining client relationships are periodically included in professional development activities• is resourced, or pursues additional resources, to enable case management work for complex cases involving children. Where the organisation is unable to undertake this function, they endeavour to locate an appropriate, child safe agency who can
There is evidence that staff:	<ul style="list-style-type: none">• offer to take an advocacy approach when working with clients and children who have child protection concerns

6.6 Data collection and security

The organisation has systems in place to ensure that all data collection systems align with National and relevant state/territory legislation and Australian Privacy Principles (APPs).

Meeting National Standards

<p>There is evidence that the organisation:</p>	<ul style="list-style-type: none"> • has policies and procedures in place to guide the collection, storage, use and protection of client data at all client contact points of the organisation • can demonstrate that its information/data collection and management practices are consistent with the Australian Privacy Principles and any relevant state/territory health records legislation and within the requirements of any professional association staff may be members of • ensures that any service reports, data collation, statistical analysis, and all relevant documents are de-identified prior to publication/use • analyses data collected to identify trends and barriers in service provision
<p>There is evidence that staff:</p>	<ul style="list-style-type: none"> • are confident and transparent in discussing why data is collected and how it is used

6.7 Client records

Recording keeping is an integral part of professional clinical practice. Accurate and comprehensive records facilitate case planning, evaluation, continuity of care, report writing and interagency collaboration. They also enable services to be accountable to clients, funding bodies and the community. Client records can take a range of forms, including:

- Intake forms
- Counselling notes
- Emails to/from clients
- Telephone messages to/from clients
- Reports to authorities or other services/agencies
- Advocacy letters and reports
- Records of sessions and service activities attended
- Referral forms.

Client records should contain sufficient information to ensure that:

- The organisation can report on the quantity and type of services delivered to clients
- Sufficient demographic information is captured
- The organisation can demonstrate that child protection obligations are discharged
- Confidentiality and informed consent procedures are complied with.

Additions to client files, including counselling notes, should be made in a timely manner to reduce the risk of data/information loss, and to ensure accuracy. Client files are the property of the organisation, not the practitioner or the client. All staff should be aware that clients can ask to view their client record at any stage. This is an important consideration which should shape the manner in which records are formulated.

It is essential that the collection of any records is consistent with the Australian Privacy Principles (APPs), as well as any state/territory health records legislation or regulations. In addition, policies, and procedures specific to the organisation may play a role in how client information is recorded and stored.

Systems should be in place to ensure that all client records are made and stored securely. Any electronic records must be secure and backed-up to avoid file loss or unauthorised access. Organisations must comply with legal obligations regarding the storage of archived client records.

Organisations must be aware of communication privilege laws in their state or territory and advise clients of the possibility of their records being subpoenaed for legal matters.

Meeting National Standards

There is evidence that the organisation:

- has policies and procedures in place to guide the collection, storage, use and protection of client information
- has policies and procedures in place to comply with a subpoena that are consistent with communication privilege laws in their state/territory
- has policies in place that identify exceptions to confidentiality
- organisation can demonstrate that its practices are consistent with the APPs, relevant state/territory legislation or regulations as well as any professional associations to which staff may belong
- deidentifies any occasions of service or service statistics prior to their inclusion in any documents it releases
- has systems in place to facilitate client access to their own file upon request, and these procedures protect client safety and wellbeing, as well as the security of the file

There is evidence that counselling staff:

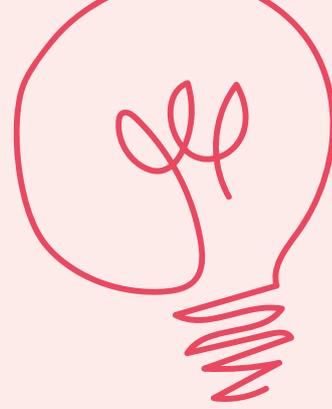
- record the goals of the client in their file, as well as the client and counsellor's views of progress against these goals

Exceeding National Standards

There is evidence that the organisation:

- undertakes an annual audit of client files and communicates any findings to all staff
- has strategies in place to improve record keeping practices and supports individual staff to improve practice if issues in their record keeping practices have been identified
- requires that counsellors and their clinical supervisor periodically review case files and records of the review are included in the client file

STANDARD 7



Valuing Innovation and Quality Improvement

Effective quality improvement processes can assist services to achieve a high standard of professionalism and deliver high quality services to victim-survivors. Quality improvement should be demonstrated by accurate data collection, streamlined reporting and ongoing evaluation of service provision.

Innovation requires regular evaluation and review of services and practice methods, knowledge of the current evidence-base, and translating this knowledge into practice to ensure effective service provision. Collaboration and integration with other services and developing referral pathways is a key component of innovative practice to meet the needs of victim-survivors. Specialist sexual violence services should also contribute to practice knowledge through participation in research and building connections with local tertiary institutions.

Examples of innovative practice that specialist sexual violence services could consider include healing approaches and restorative justice. Organisations such as the Healing Foundation have articulated Aboriginal and Torres Strait Islander healing as a holistic process in which the importance of being trauma informed is viewed as central (Quadara & Hunter, 2016). Refugee communities may also feel that community strengthening and healing may be an important precursor to the implementation of trauma-informed models of care. Restorative justice approaches may be used to acknowledge the impacts and harms caused by a crime and discuss the way forward (Bolitho and Freeman, 2016), either within or alongside the formal criminal justice system.



7.1 Continuous quality improvement

The organisation is able to describe and demonstrate its quality improvement and quality assurance practices in order to promote quality service responses and continuity of care to people who have experienced sexual assault and their families/significant others.

Meeting National Standards

There is evidence that the organisation:

- has established a Quality Improvement Framework that is regularly reviewed and actioned
- is actively working towards accreditation with an approved accreditation body
- actively fosters continuous learning at all levels
- evaluates service delivery

There is evidence that all staff:

- participate in quality improvement initiatives
- have current accreditation with their professional association, or are eligible for registration
- are supported to regularly attend professional development and share new information throughout the organisation

Exceeding National Standards

There is evidence that the organisation:

- the organisation maintains accreditation status through a reputable quality improvement program
- the organisation communicates quality improvement initiatives to key stakeholders

7.2 Innovation in response, collaboration and integration

Innovation requires thought leadership and an ongoing process of review of current evidence and application of this knowledge to practice. Collaborative practice and integrated service delivery is a key element of good practice in responding to sexual assault. Organisations should maintain close interagency relationships, formalise interagency agreements and collaborate locally, and within relevant jurisdictions to provide effective services. Responses to people with complex needs often necessitate collaboration and integration to be effective.

Meeting National Standards

There is evidence that the organisation:

- ensures all staff are familiar with and adhere to relevant legislation and policy
- establishes and maintain processes to ensure ongoing collaboration with interagency partners that gives priority to the needs of clients
- supports the lead of other agencies, depending on the nature of the collaboration
- develops and maintains respectful and effective collaborative relationships with Aboriginal and Torres Strait Islander organisations
- shares information related to cases in accordance with legislation and policy
- obtains written consent from the client (where appropriate) before collaborative work commences, including consent to which agencies will be involved and the level of and content of information shared between agencies, in accordance with relevant legislation and policy. This must be done in an age-appropriate and developmentally appropriate way work involving children and young people
- supports staff to actively participate in case-planning in relation to the safety, protection and ongoing care and support of clients. This is of particular importance if it concerns clients with additional needs, such as a physical or intellectual disability or mental illness. Where possible, the client will be informed and invited to participate if appropriate
- supports staff to participant in relevant local initiatives, committees and interagency networks that relate to the needs of victims/survivors
- ensures community education and prevention activities are developed and conducted in partnership with communities and government and non-government agencies, ensuring to observe culturally appropriate protocols for the relevant community

Exceeding National Standards

There is evidence that the organisation:

- lead collaborative work depending on the nature of the collaboration, client need, agreements with the client, and service capacity
- collaborate to develop innovative models of service provision that are responsive to local needs and actively promotes these

7.3 Consideration of healing approaches

The Healing Foundation considers healing for Aboriginal and Torres Strait Islander people to be:

” ... a holistic process, which addresses mental, physical, emotional and spiritual needs and involves connections to culture, family and land. Healing works best when solutions are culturally strong, developed and driven at the local level, and led by Aboriginal and Torres Strait Islander peoples.” (Healing Foundation, 2021)

Aboriginal and Torres Strait Islander communities often face challenges in accessing services that are culturally safe and appropriate. Sexual violence services have a responsibility to honour the resilience and deep connection to culture, kinship, family and history, to actively address injustice and to support resilience and healing in responses to sexual assault. In some but not all instances, preferred responses will involve healing approaches.

Meeting National Standards

There is evidence that the organisation:

- listens to and learns from Aboriginal and Torres Strait Islander peoples
- prioritises cultural safety and cultural competence
- engages in cultural consultation about healing approaches
- supports and actively promotes an Aboriginal and Torres Strait Islander workforce
- respects community cultural protocols and differences in communities

Exceeding National Standards

There is evidence that the organisation:

- is sought out by Aboriginal and Torres Strait Islander communities to support healing approaches to sexual violence

7.4 Consideration of restorative justice approaches

Restorative justice most commonly refers to practices used after harm has occurred and to practices that operate within or alongside a formal criminal justice system. Bolitho & Freeman (2016) reviewed restorative practice that attends to the issue of child sexual abuse for the Royal Commission into Institutional Responses to Child Sexual Abuse. The evidence suggests that restorative justice can be practised to good effect following sexual abuse however, outcomes were seen to be contingent on the following particular conditions:

- specialism which includes facilitator skill, knowledge and experience
- vigilant use of screening (relating to suitability, not just eligibility)
- the use of experts (in sexual offending and the dynamics of violence) throughout the process
- flexibility and responsiveness to participant needs
- timing of the meeting appropriate to victim-survivor readiness
- and for offenders, participation in a targeted sex offender treatment program

Meeting National Standards

There is evidence that the organisation:	<ul style="list-style-type: none">• provides accurate information to victim-survivors about restorative justice approaches• makes an informed policy decision about whether to support and/or provide restorative justice approaches
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Exceeding National Standards

There is evidence that the organisation:	<ul style="list-style-type: none">• seeks advice and works in collaboration with criminal justice agencies and experts if development of a service is determined• provides restorative justice services to victim-survivors ensuring all evidence-based conditions are fully enacted
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7.5 Contributing to practice knowledge through research collaborations

Meeting National Standards

There is evidence that the organisation:

- prioritises the highest quality services by drawing on evidence based clinical practice, research and evaluation
- advocates for opportunities to participate in local, state and federal research
- ensures that intent or rationale for research is consistent with the philosophy of NASASV and consistent with these standards
- adheres to relevant ethical standards in engagement of clients for research purposes

Exceeding National Standards

There is evidence that the organisation:

- advocates for the generation of research, practice and policy information to inform the community of sexual assault prevention
- builds research capacity into the organisation
- initiates research collaborations with tertiary institutions to increase understanding of the nature and incidence of sexual assault

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