Standards of Practice Manual

for

Services Against Sexual Violence

2nd Edition

National Association of Services Against Sexual Violence

Produced by NASASV 2015

Rape & Domestic Violence Services Australia

This project was funded by NASASV for, and on behalf of, the Australian sexual assault services sector.

Development of the Standards and Acknowledgements

The National Association of Services Against Sexual Violence initiated a review of its National Standards in 2012 with the aim of bringing the Standards into line with current evidence and practice. A Steering Committee comprised of members of the NASASV Board of Management was established to develop the project guidelines and provide oversight, guidance and support throughout the life of the project.

In August 2012 a part-time researcher and writer was employed to conduct the project in line with the NASASV project brief. The project consisted of the following elements:

Review of existing National Standards of Practice Manual for Services Against Sexual Violence, 1st edition.

Literature review of relevant national and international research and service standards, consultations with experts in the field.

Report of findings, recommendations and draft framework for new Standards.

Drafting Standards, 2nd edition.

National consultation on draft with sexual assault services and other key stakeholders in all states and territories. Input and feedback was received from over 70 experts across Australia from 39 different services (see Appendix)

Reporting of consultation findings and recommendations to Steering Committee.

Review and update of draft Standards with further sector consultation.

Presentation of final draft to NASASV Steering Committee.

Special Thanks

For support, guidance and input from the project Steering Committee:

Karen Willis, Executive Officer, Rape & Domestic Violence Services Australia, and Deputy Chair NASASV

Eileen Oates, Chief Executive Officer, Loddon Campaspe Centre Against Sexual Assault

Katrina Dee, Manager, Yarrow Place Rape and Sexual Assault Service

Samantha Bowden, Coordinator, Ruby Gaea, Darwin Centre Against Rape

And all members of the NASASV Board both past and present.

Special thanks to all those in the sector who participated in consultations, generously shared their expertise and provided feedback and suggestions on draft sections. Also thank you to the office team at Rape Crisis NSW for their admin support and assistance.

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Introduction

i. The Standards of Practice Manual – 2nd Edition

Aims of these Standards:

- *to define and describe an expected quality of service provision which reflects the mission statement and philosophical underpinning of the National Association of Services Against Sexual Violence (NASASV)*
- *to promote, through the development of best practice models, the best possible services for clients*
- *to promote equity of access to services for all clients within our Culturally and Linguistically Diverse (CaLD) society*
- *to promote community awareness and understanding of sexual violence in the context of power and gender relations*
- *to promote the professional status and credibility of services against sexual violence.*

Objectives of these Standards:

- *provide Services with a tool to assist them to provide high quality services*
- *provide guidelines for service development, planning and quality assurance*
- *provide a framework for developing a consistency of quality across the sexual violence service sector, and*
- *educate and inform government, relevant agencies and the wider community about the policies and practices of services against sexual violence.*

These standards focus primarily on delivery of services to adults (female and male) who have experienced sexual assault and adult survivors of childhood sexual abuse.

Signpost for Future Work:

NASASV recognises the need for the development of national standards of practice for services:

- *working with children and young people who have experienced sexual assault and/or sexual abuse,*
- *working with children and young people who display problem sexual behaviours*
- *working with children or young people who display offending behaviours.*
- *perpetrators of sexual assault/abuse*

Structure of the Manual

The Standards manual is divided into 10 sections, each section covering an area of the organisation or major aspect of service delivery. Each section is prefaced with a short introductory reading, the purpose of which is to:

- *provide readers with an understanding of the research and industry expertise which has informed the development of these Standards*
- *provide those who are relatively new to work in this field with an orientation to sexual assault services.*

Standards within each section contain a brief summary statement of intent, followed by a list of standards considered minimum practice, and those which are aspirational.

ii. The Sexual Assault Services Sector

Scope of Services

The spectrum of services and programs across the sexual assault services sector is broad, reflecting federal and state government funding priorities, how services are coordinated throughout the state/region, local community needs and organisation purpose. The range of services may include, but is not restricted to, any of the following:

- *assessment and referral*
- *case management*
- *short, medium or long term counselling/therapeutic interventions*
- *services provided in the face to face, telephone and online environment*
- *therapeutic groups*
- *education programs for clients, school/community groups, other professionals*
- *support programs for families*
- *health promotion programs*
- *systems advocacy*
- *collaboration/partnerships with other services or professionals*

The client group/s assisted will also reflect program and funding and may include:

- *adults who have experienced recent or historical sexual assault*
- *adult who experienced sexual assault in childhood*
- *children and young people who have experienced sexual abuse*
- *non-offending supporters of those who have experienced sexual assault*
- *children or young people with problem sexual behaviours*
- *perpetrators of sexual assault*

Within these broad target groups will be variation in particular needs as determined by cultural profile, geographic location, other supports available and so on.

Meeting the needs of diverse cultural groups such as Aboriginal or Torres Strait Islanders, people from CaLD backgrounds, new arrivals, refugees, homeless young people, people of diverse sexualities, those from the range of socio-economic backgrounds and those who have a disability or mental health issues and those impacted by alcohol and other drugs (AoD) requires more tailored and targeted skills.

Service or program type should appropriately match the context of the trauma experience for each client group.

NASASV embraces the breadth of the sector as a strength and promotes the commonalities in each service for the benefit of all. Variations can be celebrated for bringing depth of knowledge and experience to the sector as a whole and for providing a range of services to the community.

Complex Work

The field of sexual assault is a specialised area, therefore each type of service and client group requires specialised skills. Services and individual practitioners will often be responding to complex needs in multiple client groups. Service or program type should match appropriately to the client group in recognition of differing needs associated with the spectrum of trauma impacts and reactions.

Assisting victims of sexual assault also requires knowledge and skills in a range of associated fields these include but are not limited to the following: family systems, mental health issues, alcohol and other drugs (AOD) , family and domestic violence, depression, anxiety, eating disorders, self harming behaviours, suicidal ideation, relationship and homelessness issues.

Knowledge of other sectors, and how they function is often required including housing, police, medical and forensic services, child protection agencies, legal services and systems, interpreters, advocates, family law, education, and a host of social services, both government and non government.

Practitioners will be required to undertake comprehensive assessments to be able to identify appropriate therapeutic responses, identify other required support services, make appropriate referrals, advocate for client needs, collaborate and coordinate with other agencies, and case manage.

NASASV recognises the complex, specialised and sometimes challenging nature of providing sexual assault services within dynamic communities, often insecure funding models, and shifting external pressures.

Practitioners require access to a secure and supportive working environment and ongoing professional development opportunities.

NASASV calls for capacity building of the sector to meet the growing demand as an increasing number of those who have experienced sexual assault make the decision to seek professional support in their recovery and redress through the criminal justice system for the crime they have experienced.

iii. Supporting Frameworks

There are a number of key frameworks that underpin the delivery of services across the sector. The frameworks are complimentary to each other and reflect the depth of knowledge around the impacts of sexual assault, the development of theoretical constructs and the evolution of each organisation over time.

Trauma Model of Recovery

The word 'trauma' refers to two things: the actual traumatic event/s and the trauma response/s experienced by the person. It is well established that sexual assault in adulthood and childhood are traumatic events.

NASASV adopts a broad perspective of trauma and accepts that each person's experience and expression of trauma is personal, unique and not only a function of the particulars of the assault (two people may respond differently to a shared experience), but also the person's history and trauma history, relationship with the perpetrator, stage of life, support networks, cultural context and socialisation.

Recovery from trauma involves progression through a number of stages. For these standards we draw on the work of Herman and other experts in the field and summarise them as:

Contemplation and preparation for safety

1. *The establishment of safety*
2. *Remembrance and mourning/ Processing trauma; and*
3. *Reconnection with ordinary life.*

These are simplified headings for complex processes and no individual will progress through them neatly or in a linear fashion within the recovery process, but over the course of successful therapy they will "have a gradual shift from unpredictable danger to reliable safety, from dissociated trauma to acknowledged memory, and from stigmatized isolation to restored social connection." (Herman, J. 1992, Chapter 8). Each aspect of service delivery from initial contact with the client through to cessation of service, and each practitioner along this pathway will have a role to play in that client's journey toward recovery.

Feminism and Gender Awareness

Two central features of psychological trauma are disempowerment and disconnection from others and self. Recovery therefore, must be based within empowerment, new connections and in the context of relationships. Attention to power imbalance are critical elements across all aspects of service delivery (Herman, 1992), and congruent with feminist and gendered frameworks.

Both frameworks recognise that sexual assault is a consequence of, and reinforcement of, power inequality. Feminist services, arising out of the women's movement recognised these imbalances in social constructs and seek to address these imbalances and to restore dignity, strength and power back to the client, and advocate for social justice and equality.

The frameworks also recognise that men are subject to stereotypes and the dominating social expectations around traditional models of masculinity; and that both sexes can experience detrimental consequences resulting from these gender expectations and the violent use of power.

Sexual assault service delivery (from initial contact to the end) will be informed by the trauma model of recovery and feminist / gender discourse. The practitioner should pro-actively address the inherent power differential between themself and

their client. There will also be elements of consciousness-raising, social and gender-role analysis, re-socialisation and, to varying degrees, social activism (Israeli, A & Santor D, 2000).

In achieving this it is essential that the practitioner operate from a client centred and empathic position and use strengths based interventions. Most importantly, the practitioner will recognise the power imbalance inherent in the relationship and not misuse that power.

Client Centred Care

Irrespective of the range of services the organisation delivers, each will have client Centred Care as a founding set of principles. In summary, the principles of Client Centred services are:

- *validating the client's experience of the sexual assault and trauma*
- *not judging the client, or making assumptions about what she/he needs*
- *being guided by the client and addressing the client's stated priorities*
- *offering choices/alternatives to the client, and seeking informed consent*
- *prioritising safety, dignity and respect*
- *providing sufficient time for the client to respond*
- *working together to demonstrate the client's own power and resources*
- *being open, honest and respectful*
- *involving clients in service design and evaluation.*

Victims Rights

Consistent with providing holistic quality care and restoring power and dignity to the client, NASASV subscribes to the United Nations Declaration of Victims Rights:

- *the right to be treated with respect and recognition*
- *the right to be referred to adequate support services*
- *the right to receive information about the progress of the case*
- *the right to be present and give input to the decision-making*
- *the right to counsel*
- *the right to protection of physical safety and privacy*
- *the right of compensation, from both the offender and the State*

(United Nations Department of Public Information, February 2000).

iv. Key National and International Documents and Plans

National Plan to Reduce Violence Against Women and their Children Second Action Plan 2013-2016

NASASV welcomes the National Plan to Reduce Violence Against Women and their Children Second Action Plan 2013-2016. This plan continues the focus of the first action plan on prevention and providing a coordinated framework that will see all governments working together to reduce violence in the community. The Second Action Plan is divided into six National Outcomes :

1. *communities are safe and free from violence*
2. *relationships are respectful*
3. *indigenous communities are strengthened*
4. *services meet the needs of women and their children experiencing violence*
5. *justice responses are effective*
6. *perpetrators stop their violence and are held to account.*

The National Plan is endorsed by the Council of Australian Governments (COAG, February 2012).

Convention on the Rights of the Child

The Convention is the legally binding international instrument that incorporates the full range of human rights: civil, cultural, economic, political and social rights. It was developed in recognition of the fact that people under 18 years old often need special care and protection, by virtue of the fact that they are not adults. The basic human rights that children have are:

1. *the right to survival*
2. *to develop to the fullest*
3. *to protection from harmful influences, abuse and exploitation*
4. *to participate fully in family, cultural and social life.*

The Convention has four core principles: non-discrimination; devotion to the best interests of the child; the right to life, survival and development; and respect for the views of the child. The Convention sets standards in health care; education; and legal, civil and social services.

(UNICEF, 2012)

v. The 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 Association understands that:

- *Sexual violence is an abuse of power which is most often committed by men against women, children and other men.*
- *Sexual violence is both a consequence and reinforcement of power disparities between individuals and in society. Attitudes, beliefs, laws and social structures which allow or support the power of one group over another, or which allows or supports violence, contributes to the problem of sexual violence in society.*

The NASASV is committed to addressing inequalities in society which may perpetuate sexual violence including: gender, race, culture, age, ability, religion, sexuality and class.

Sexual violence includes a range of violent behaviours, including unwanted touching, sexual harassment and intimidation, coerced sexual assault and rape and other physical violence and threat to life.

Sexual violence can have a range of impacts on the individual and society. These can include physical, emotional, economic, social, psychological, legal, health, political and spiritual consequences. The impacts can be compounded by factors such as gender, race, culture, age, religion, ability, sexuality, language and class.

Empowerment of those who have experienced sexual violence is essential to redress the impact of sexual violence. Services can work towards empowerment by:

- *ensuring that the views of those who have experienced sexual violence are sought and used to influence service provision*
- *promoting the rights of those who have experienced sexual violence through the provision of information, options and choices, and*
- *ensuring that decisions about accessing services are in the hands of the person seeking assistance.*

Services against sexual violence are committed to the principles of access and equity and aim to reflect the diversity of the communities they serve.

Sexual violence is a crime against the individual and society. All sectors of the community, including government, should work towards the elimination of sexual violence.

In assisting those who have experienced sexual violence services will recognise that the mental health impact of sexual violence is a traumatic response and provide services within a trauma framework.

Services provided will be:

- *evidence based and best practice*
- *provided within a framework of quality assurance and quality improvement, and*
- *be systematically evaluated.*

The Key objectives of the NASASV

1. *To co-ordinate the sharing of information, skills and resources between services and state and territory networks on all aspects of service provision and co-ordination.*
2. *To assist governments in developing policies for building safer communities.*
3. *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.*
4. *To promote an understanding of sexual violence in the context of gender and power relations.*
5. *To promote equity of access to services for all those who have experienced sexual violence, recognising that women and children are the predominant group, paying particular attention to those most marginalised on the basis of their race, culture, gender, disability, age, language, sexual orientation and geographic location.*
6. *To promote community awareness of sexual violence and its personal and social consequences at a state, territory, national and international level and to support and facilitate the community education, community development and primary prevention role of services at a local level.*
7. *To undertake research relating to service provision for those who have experienced sexual violence.*

8. *To provide information on training development and resources to services and to promote high quality training and skills development for workers through liaison with relevant national, state and territory training bodies and participation in the development of accredited training.*
9. *To monitor the range and diversity of service models and promote, through the development of best practice models, the best possible services for survivors.*
10. *To organise and facilitate national meetings, conferences and seminars.*
11. *To undertake any other activities necessary to fulfil the purpose of the organisation.*
12. *To actively seek to engage with newly emerging sexual assault services.*

Background to the Standards

In March 1993, the National Committee on Violence Against Women (NCVAW) released recommendations and findings from its National audit of services to victims/survivors of sexual violence. This audit highlighted the need for National standards and protocols to enhance the quality of service response to victim/survivors of sexual violence. It recommended that such standards of practice be developed through consultation with all States/Territories (Orr 1993:3).

Subsequent to the establishment of the National Association of Services Against Sexual Violence (NASASV), one of the priority areas was the development of National standards of practice for Services against sexual violence. It was considered important to create a tool which:

- *Reflected best practice standards nationally*
- *Represented the years of development by feminist and women's services of the highest standards of practice in support and advocacy for victim/survivors of sexual assault, including women, children and men*
- *Promoted parity of service provision.*

The Office of the Status of Women supported this priority by funding the first edition of the National Standards of Practice, which was released in 1998.

In 2011 the NASASV reviewed the Standards of Practice and decided that while many of the Standards continue to be applicable, many needed updating to reflect the changes of the intervening years.

This second edition reflects the standards that the sector currently hold as best practice and includes, in some areas, aspirational standards that services may work toward meeting within a stated timeframe.

The Standards are based on, and referenced to, evidence of worldwide best practice and were developed in consultation with services in all Australian states and territories.

The Standards

Section 1: The Organisation

The service model, range of programs and level of advocacy an organisation delivers will be driven by its stated purpose and funding agreement/s.

Good Governance

All organisations will benefit from good governance. This is about having effective systems and processes for the direction, control and accountability of the organisation, and comprises:

- *fiduciary duty: accepting responsibility for all aspects of the organisation: guarding the vision, purpose, values and assets*
- *diligence: being honest and careful in decision making*
- *responsibility: making sure the organisation has a current strategic direction and is informed about its progress*
- *accountability: ensuring financial accountability and management*
- *probity: protecting the integrity of the organisation and declaring and managing conflict of interest.*

(Source: Bradfield & Nyland, 2002a. 29 in 2012 NCOSS)

Organisation Leaders

The governing body and senior/executive management team are the leaders of the organisation and are key champions for social change, for the development and maintenance of the service, for the rights and needs of people who have experienced sexual assault. The leadership team ensures that all activities of service are informed by, and will be strengthened by principles of feminism, a gender analysis, victim's rights, client centred care and advocacy.

Management Team

The management team is charged with the responsibility of implementing the organisation's strategic directions. Good management will involve establishing and maintaining an effective working environment (internal and with external agencies), transparent communication, clear lines of delegation, maintaining and monitoring standards, ensuring sufficient and current policies and procedures, ethical decision making within the team, being risk aware and responsive, and sound financial management and reporting.

While a full spectrum of services and programs are needed, each organisation's governance structure, purpose and funding mix will determine the level of prevention it works within, and the forms of advocacy it undertakes.

There are three levels of prevention: primary, secondary and tertiary.

<u>Primary prevention</u> addresses underlying causes e.g. gender inequality, violence supportive attitudes and social norms. It seeks to prevent the development of risk factors associated with violence against women and enhance protective factors.

Primary prevention is most successful when carried out as part of comprehensive, multi-sectoral whole of community approach. Services funded to provide primary prevention interventions such as education programs are encouraged to draw guidance from the standards produced by NASASV: Framing Best Practice: National

Standards for the Primary Prevention of Sexual Assault Through Education (2009. NASASV)

Secondary Prevention encompasses early identification and intervention and work with individuals and groups at high risk of perpetration. It also involves working with those who may be at high risk of experiencing violence to reduce their risk factors.

Tertiary prevention encompasses crisis care and psychosocial support; healthcare; counselling; advocacy; safety and protection from further violence; criminal justice responses to perpetrators aimed at punishment, rehabilitation, and prevention of further violent behaviour; and case management.

NASASV recognises that international approaches are moving toward using a public health approach which incorporates an ecological model, identifies risk factors and works at the individual, relationship, community and societal level to reduce sexual assault .

Advocacy

NASASV understands that, systems advocacy is a political process by an individual or group which aims to influence policy and resource allocation within political, economic and social systems and institutions. There are many forms of systems advocacy and many activities within its spectrum.

Systems Advocacy

Systems advocacy works at the systems level aiming to benefit many and could include, for example, raising the profile of issues in the media, promoting systems change to government services, advocating for additional funding and programs to address service gaps, such as increased levels of affordable safe housing.

This form of systems advocacy can be opportunistic, for example, flagging emerging needs, contributing to policy, writing submissions and responding to inappropriate press coverage.

Systems advocacy is not necessarily adversarial, but rather contributes to a more respectful and just society in the face of disempowerment of those who have experienced sexual assault.

Individual and Client Advocacy

This involves advocacy to meet the specific needs of an individual client, for example, negotiating for client access to secure housing, mental health services and pro-bono legal support.

Advocacy for client needs is often an ongoing component of direct service delivery, and thus a legitimate and necessary part of each practitioner's role. Advocacy at the individual level may occur on behalf of the client (with their consent), or in partnership with the client. All forms of client advocacy require consent of the client and care must be taken to protect client confidentiality (See Section 7: Client Confidentiality).

Client advocacy has potential to feed into higher level systems advocacy by reducing the risk of re-victimisation and reinforcing the call for structural reform and appropriate community responses to sexual violence.

NASASV supports and calls for advocacy and intervention strategies across the full spectrum of prevention from primary through to tertiary.

1.1 Organisation Purpose, Vision, Values

The organisation has an overarching purpose, vision and values reflecting client centred care, victim's rights, principles of feminism and gender awareness; the recognition that the mental health impact of sexual assault is trauma, and that advocacy is a key element in service delivery.

The governing body and management team are the champions of the organisation's purpose and vision and strive to reflect the values of respect, openness, fairness and justice.

Minimum Practice

There is evidence to show that:

- ☐ the organisation has a current purpose, vision and values consistent with underpinning conceptual frameworks of the sexual assault services sector
- ☐ the purpose, vision and values has been developed with input from staff members and management
- ☐ the purpose, vision and values is accessible to staff members, clients and the community
- ☐ the organisation recognises their role in advocacy at governance, management and service delivery level

Best Practice

There is evidence to show that:

- ☐ the purpose, vision and values has been developed with input from client representative groups and other community partners/stakeholders.

1.2 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.

Minimum Practice

There is evidence to show that:

- ☐ the organisation has sufficient policies and practices in place to ensure good governance.
- ☐ the organisation is managing risk at all levels including governance, human resource functions, financial management, IT systems, work health safety, client services.
- ☐ the organisation has transparent communication systems.
- ☐ lines of accountability and delegations of authority are clearly articulated.

- ☐ the organisation is responsive and compliant with relevant legislation, regulations and codes of professional practice.
- ☐ all staff members have the resources and support required to perform their tasks to the highest possible standard.
- ☐ all staff members can articulate how their role contributes to the purpose, vision and values of the organisation.

1.3 Planning & Evaluation

Planning and evaluation assists services to achieve a high standard of professionalism and function throughout the organisation and to deliver quality services to the community.

The organisation has a participative and reflective approach to planning and evaluation.

Minimum Practice

There is evidence to show that:

- ☐ there is clear linkage between the organisation's purpose and values and its planning framework
- ☐ the organisation's plans (strategic, business) contain clearly articulated goals with related objectives, strategies, time frames, outcome indicators and evaluation methods
- ☐ all managers and staff members are actively involved in the planning and evaluation process.

Best Practice

There is evidence to show that:

- ☐ the organisation's plans are informed by its Complaints Register, Quality Assurance and Quality Improvement Register, Exit Interview Register, HR Issues Register, organisational statistics and evaluation of current and prior service
- ☐ the organisation seeks input from client representative groups, other key stakeholders in its planning and evaluation.

1.4 Quality Improvement

The organisation is able to describe and demonstrate its quality improvement and quality assurance practices.

Minimum Practice

There is evidence to show that:

- ☐ the organisation has established a Quality Improvement Framework
- ☐ staff members participate in quality improvement initiatives

- ☐ the organisation is actively working towards accreditation with an approved accreditation body.

Best Practice

There is evidence to show that:

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

Section 2: Cultural Competency

First Australians

NASASV recognises the unique position of Aboriginal and Torres Strait Islander people in Australia's history and society today. NASASV recognises Aboriginal and Torres Strait Islander people as Australia's indigenous people, the first Australians. NASASV recognises that the indigenous community is not one, singular group, but are diverse and multi-cultural groups.

As the first Australians, indigenous people have experienced the full history of European colonisation patterns of the past as well as the impact of government and organisation social policies and practices. Many past policies and practices arose out of cultural imperialism, ignorance and racism, and have been very damaging. NASASV acknowledges that the welfare or social services sector has contributed to, and participated in, destructive practices, and that the legacy of that history is still felt today. NASASV also acknowledges that inherent attitudes of cultural imperialism, ignorance and racism are still part of contemporary life for indigenous people and may be felt in a wide variety of contexts, including the accessibility and relevance of social and health services.

NASASV supports the UN Declaration on the Rights of Indigenous Peoples and sexual assault services will strive to uphold the Declaration's central right – that of self-determination. Self-determination means that, as a collective, indigenous people:

- *Should have a choice in determining how their lives are governed*
- *Should be able to participate in decisions that affect them*
- *Should have control over their lives and development*

(Australian Human Rights Commission. 2010 Community Guide to the UN Declaration on the Rights of Indigenous Peoples. Short Version: Strong Cultures, Proud People).

Cultural Competency

These standards recognise a much broader definition of culture and promote cultural diversity as embracing race, ethnicity, language, cultural practices, religious beliefs, values, gender, sexuality, age, ability, socioeconomic status, political views, geographic location, lifestyle and living conditions, and the like. In order to provide effective and culturally appropriate services organisations and practitioners need to be willing to address issues of difference arising out of race and, more broadly, culture.

While many services may welcome diverse populations into to their service, unless the service itself is able to recognise that attending to diversity requires constant learning, reflection and willingness to be flexible, to explore values and beliefs with clients, and be challenged, then the service may be both culturally inappropriate and therapeutically ineffective.

When, where, why and whether a client seeks help from a service is influenced, in part, by their individual cultural beliefs and practices. The main goal, of cultural competency, therefore, is to modify or tailor services to resonate with the perspective of each client, so that each client may be served effectively.

Cultural competency is a continuous and conscious process, fluid and dynamic where the organisation as a whole and individual workers strive to find meaningful and useful service delivery strategies based on knowledge of the cultural heritage, beliefs, attitudes and behaviours of the client and in consultation with that client.

A continuum of cultural competency has been described (Cross et al, in Olavarria, et al, 2009) to assist organisations in assessing their level of cultural competency. Cultural destructiveness has been described as policies, attitudes and practices which intentionally have a negative impact on a cultural community. Cultural incapacity refers to organisations which are inadvertently biased and have no capacity to assist minority or marginalised people. Cultural blindness refers to the assumption that all people benefit from the same service irrespective of ethnicity or race. Organisations which are culturally pre-competent are those that recognise their weakness in serving minority groups and are taking some steps to improve some aspects of their service. Culturally competent organisations are those that respect difference and undertake ongoing reflection on their ability to meet the needs of culturally diverse groups, are attentive to the dynamics of difference and take active steps to increase their knowledge of difference, adapting their services accordingly. A culturally proficient organisation is one which develops and evaluates new interventions and takes steps to change structures and systems to better support diverse cultural values and beliefs of their clients.

One model of cultural competency (Suarez-Balcazar, et al 2011) describes three necessary factors: (1) developing cultural awareness/knowledge of differences, specific practices, people's experiences of oppression and marginalisation, discrimination, and becoming aware of one's own cultural biases. (2) developing the cultural skills in professional practice to modify, adapt and improve service delivery. (3) organisational context/support for multicultural practice and the demonstrated commitment to developing cultural competency across the organisation.

Cultural competency recognises that minority or marginalised groups are relatively disempowered and disenfranchised from the main/dominant culture – usually the one which is providing the service. NASASV recognises that issues of cultural dominance or imperialism may be of much greater relevance to the client than a feminist or gendered perspective and may present a more significant access barrier. However, consistent with gender aware services, culturally competent ones seek to continually recognise cultural power imbalances and work within a framework that seeks to redress and equalise the relationship between the provider and client.

These standards recognise that it may not be possible to be equally familiar with all cultural groups but that developing cultural sensitivity and recognising and trying to assess its own cultural biases and assumptions are fundamental first steps on the road of cultural competency is. Working in an inter-cultural space is a two-way dynamic that involves interaction and reflection between the organisation, its staff and the groups/individuals it aims to assist.

Special Consideration

It is recognised that sexual assault services are often under-resourced and provide barriers to making services accessible to the most marginalised groups. Those most marginalised may include, for example:

- *Aboriginal and Torres Strait Islander people*

- *refugee groups*
- *those with mental illness*
- *children and young people*
- *those who have a disability*
- *those referred to as Gay, bi-sexual, lesbian, transgender people who have experienced sexual assault*
- *sex workers*
- *any other group currently not accessing services.*

See also Section 3: Increasing Access.

Therapeutic Relationship

The term "culture-infused counselling" (Collins & Arthur 2010) has been proposed to describe the concept of a culturally sensitive working alliance between therapist and client which places culture in the centre of every interaction between client and practitioner.

Supervision

Cultural responsiveness in the context of supervision has been defined as "Supervision 'responses that acknowledge an existence of, shows interest in, demonstrate knowledge of and express appreciation for the client's [and supervisee's] ethnicity and culture and that place the client's [and supervisee's] problem in a cultural context'' (Burkard, A, et al 2006).

Issues of race, ethnicity and culture should be discussed and explored through supervision. Such discussions should cover biases and perspectives of both the supervisee and supervisor. This discussion should explore how biases impact on the supervision process. The discussion should also explore how issues of race, ethnicity and culture from both client and therapist perspective may impact on the therapeutic relationship, therapeutic interventions, client engagement with the process and client outcomes.

2.1 Cultural Competency - Organisation

Organisational cultural competency refers to a coordinated or congruent set of attitudes, values, policies and practices that enable all members of a service to work more effectively in an inter-cultural context.

Strategies for increasing cultural competency are in place at all levels within the organisation: governance, senior management, managers, supervisors, practitioners, administrators.

The organisation recognises that client's past experiences of inequality, racism and cultural imperialism may pose a significant barrier to seeking support from sexual assault services.

Minimum Practice

There is evidence to show that the organisation:

- ☐ makes a clear statement that recognises and values diversity
- ☐ recognises the rights of indigenous people and their unique position as first Australians
- ☐ is committing resources to improving cultural competency of employees, particularly those with client interface
- ☐ engages in networking with diverse and minority cultural groups to inform itself and its programs
- ☐ HR policies and practices embrace and reflect cultural diversity and help manage diversity in the workplace
- ☐ seeks the involvement of staff in the process of improving cultural competency
- ☐ has strategies in place to improve access to its services by those from diverse cultures
- ☐ has policies and practices in relation to workplace discrimination and harassment and those policies and practices are included in staff orientation and are reviewed regularly within the organisation.

Best Practice

There is evidence to show that the organisation:

- ☐ has a comprehensive and integrated framework to improve its cultural competency at all levels including: a continual process of research, engagement, learning, planning, action, reflection, and evaluation
- ☐ seeks the input of diverse cultural groups to its planning and evaluation.

2.1 Know the Community

The organisation can describe the community it serves in terms of: key population groups, industries and general employment profile, relevant

geographical or spatial features, other unique features of the community, emerging groups and issues.

The organisation has awareness of the indigenous groups in the community and their priority issues.

Minimum Practice

There is evidence to show that the organisation:

- ☐ has comprehensive knowledge of the community and that this knowledge informs its strategic and service planning
- ☐ actively seeks information about rates of sexual assault within its community, and any relevant associated features
- ☐ links its clients with other relevant supporting services.
- ☐ collects demographic data about its client groups to enable it to accurately describe its service users.

Best Practice

There is evidence to show that the organisation:

- ☐ undertakes analysis of its current service users within the context of the community to enable identification of groups that are not currently able to access its services
- ☐ seeks to develop partnerships with key groups or their representative organisations in order to increase access to relevant services for those clients
- ☐ advocates for additional services and resources for those groups who are currently unable to access services and/or where appropriate services are not available.

2.3 Cultural Competency – Practitioner

Practitioners explore, understand and appreciate differences in health beliefs and behaviours and adjust their interventions accordingly.

Practitioners place culture at the centre of the therapeutic relationship and undertake a continual process of reflection and testing of their own cultural knowledge, beliefs and skills.

Minimum Practice

There is evidence to show that:

- ☐ exploration of cultural background and identity forms part of initial intake/assessment

- ☐ the practitioner explores issues of cultural perception, beliefs, knowledge and practices with the client as part of the therapeutic relationship
- ☐ where necessary, the practitioner offers and explores with the client the use of language interpreter and/or cultural advocate
- ☐ the practitioner undertakes ongoing learning about cultural beliefs, practices, and experiences of the cultural groups of his/her clients
- ☐ clinical supervision provides a forum for exploring issues of culture and bias from the perspective of client, supervisee and supervisor.

Best Practice

There is evidence to show that the practitioner:

- ☐ has tested their own cultural assumptions in the therapeutic setting through client notes and clinical supervision
- ☐ networks with agencies and population groups of diverse cultures
- ☐ utilises evidence based best practice therapeutic interventions to assist in the therapeutic relationship
- ☐ articulates specific professional development goals in the area of cultural competency in their professional development plans/annual review processes.

Section 3: Increasing Access

Substantive Equality

The principle of substantive equality recognises that a 'one size fits all' model of service delivery is not effective in meeting the needs of a diverse community, particularly when coupled with the fact that the impacts of trauma/sexual assault are individual and diverse. Substantive equality addresses systemic discrimination and recognises that if all clients were treated the same then existing inequities and access barriers would remain and be perpetuated.

While often unintended, systemic discrimination can exclude certain people from full participation in services provided by an organisation. Consistent with equality of opportunity, the substantive approach recognises that past and inherent injustices and racism create an unequal and unfair starting position.

Similar to affirmative action strategies for recruitment, organisations review service usage, and develop policies and practices with a view to identifying inherent or structural barriers and then lowering them for indigenous people, disadvantaged groups, those most marginalised and those who have suffered past or present discrimination.

A thorough understanding and knowledge of the community in which the organisation operates is an essential first step in improving access. See also Section 2: Cultural Competency.

Availability and Access

The organisation recognise that those who have been impacted by sexual violence may face multiple barriers to access support in the first instance such as knowledge of services, service type, service location, physical accessibility, and appointment time availability. Services will take active steps to identify any structural barriers in their own service and implement strategies, where practicably possible, aimed at lowering those barriers.

Community attitudes about sexual assault and those who have experienced sexual assault are also significant barriers. Perpetuation of myths around sexual assault, disbelief, victim blaming and re-traumatisation occur all too often and make it harder for people to come forward and seek support.

NASASV recognises that provision of face to face services is best practice for supporting clients who have experienced sexual assault to recover the quality of their lives. NASASV also recognises that for many clients, issues such as geographical location, mobility, potential for identification in the service location and the stage of trauma they may be experiencing, that a range of service delivery modalities is best utilised, within a best practice client centred framework. This may include face to face, telephone, online and VoIP counselling. NASASV also recognises that depending on the client's stage of recovery, this mix of modalities may change to best meet client need. Where a service may not provide all modalities, partnerships with other service who do is in the best interests of the client.

Advocacy

Sexual violence is an abuse of power which disempowers the victim and is a violation of a person's basic human rights, leaving victims with many barriers to

access the support services they need. Sexual assault services are, therefore, providing services to those who may be already marginalised from other services.

Wherever possible, sexual assault services will utilise opportunities to engage in systems advocacy on behalf of groups who do not have access to sufficient or appropriate services. Systems advocacy activities may be aimed at increasing capacity of the sexual assault service, be directed toward the capacity of another agency or service or seek to change community attitudes to sexual assault and those who experience it.

When required and possible, sexual assault services will also, with consent of the client, advocate with them, or on their behalf, for relevant, responsive and client centred services from other agencies/services.

Sexual assault services also recognise the role that specialist advocacy services, and appointed advocates can have in assisting their clients access a wide range of services, such as access to the criminal justice system and legal support, they may need.

Referral

In taking a holistic approach to service delivery, sexual assault services recognise that collaboration and partnerships with other agencies can enhance the quality of care to the client.

A personalised referral is one where contact is made with the receiving agency to ensure that the service is appropriate and available. A personalised referral may also include supporting the client to make contact and organise the referral themselves. Personalised referrals are more effective in improving access by ensuring that clients are linked to, and receive, the right service from the most appropriate agency. Referrals made in partnership with the client are also strengths based and assist in building client confidence in self advocacy.

3.1 Organisational Commitment

Reducing access barriers to service is an ongoing process involving identifying client groups who may be experiencing access barriers, what the barriers are and what is needed to reduce them.

Due to the disempowerment resulting from sexual violence, advocacy is crucial to address service gaps, improve access to existing services, and raise awareness of client group needs

Minimum Practice

There is evidence to show that the organisation:

- ☐ can articulate its capacity for service delivery
- ☐ is committed to improving access to services
- ☐ is actively engaged in trying to reduce access barriers to its services
- ☐ pursues links and referral pathways with other relevant support services that may assist in meeting needs of particular clients or client groups
- ☐ can measure the effectiveness of any access strategies implemented.

Best Practice

There is evidence to show that the organisation:

- ☐ commits resources to systems and client advocacy
- ☐ consults with marginalised groups to identify needs and barriers to service.

3.2 Counselling Mode

These standards recognise that providing high quality 24 hour, face to face services in all geographic locations is beyond the capacity of most sexual assault services.

The organisation will endeavour, where practicable, to establish counselling modes alternate to face to face, and/or referral pathways with other appropriate agencies that can provide therapeutic symptom management, counselling or assistance with other issues the client may be facing.

3.2.1 24 Hour Services

Minimum Practice

There is evidence to show that the organisation:

- ☐ has systems in place to facilitate 24 hr on-call access to sexual assault counsellors where recent sexual assault has occurred
- ☐ has systems in place to redirect after hours calls to a 24 hour sexual assault counselling service
- ☐ that provide 24 hr on-call services have sufficient policies and procedures to ensure service quality, client confidentiality, and staff member safety.

3.2.2 Outreach

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

Minimum Practice

There is evidence to show that:

- ☐ all aspects of the outreach service are subject to the same therapeutic standards as those in place at the main service location
- ☐ the organisation evaluates its outreach services
- ☐ where outreach involves service in an unfamiliar location, risk assessment and safety procedures are in place to ensure the safety of the client and practitioner
- ☐ the organisation's work health safety policies have provisions covering outreach service provision.

3.2.3 Telephone and Online, Internet Counselling

Organisations will provide access to telephone voice-over-the-internet protocol (VoIP) counselling, and/or online support, as a service in its own right, or to augment face to face counselling.

Minimum Practice

There is evidence to show that:

- ☐ organisations unable to provide telephone counselling or online support have policy and procedures in place for referral to other appropriate telephone or online counselling services.
- ☐ procedures are established for telephone and online counselling that cover:
  - establishing privacy, confidentiality and safety for the client
  - signing any associated documentation such as terms of engagement, consent forms

- ☐ systems are in place to enable development of therapeutic goals, therapeutic review and client outcome evaluation
- ☐ practitioners providing telephone counselling and/or online support receive additional training to support this form of service delivery
- ☐ counsellors working with telephone and online support systems are qualified and experienced trauma counsellors and are provided with the same level of supervision and support as face to face counsellors.

3.3 Referral

Referrals include a total 'transfer' of the client to another agency, or to additional/adjunct services for the purpose of meeting complex needs, such as psychiatric/mental health services, drug and alcohol services, disability services.

Additional client advocacy may be required in the referral process to ensure that specific needs of the client are met.

3.3.1 Referral Resources

Minimum Practice

There is evidence to show that the organisation:

- ☐ maintains up to date information about relevant services to enable high quality and appropriate personalised referrals
- ☐ builds relationships with relevant key stakeholders as part of systemic and individual advocacy
- ☐ has a wide range of relevant information readily accessible to clients.

3.3.2 Referrals Out

Minimum Practice

There is evidence to show that:

- ☐ accurate and comprehensive information is provided to the client about the proposed referral to enable an informed choice
- ☐ if given, the consent and its form (verbal/written) is recorded
- ☐ where client information sharing is required to assist with advocacy or referral, prior written consent specifying the level of information to be shared has been received from the client
- ☐ personalised referrals are prioritised over cold referrals
- ☐ clients referred out have the option to recontact
- ☐ there are procedures in place to enable follow up contact with the receiving agency and the client to check if the service has been taken up and is progressing appropriately.

See also Section 6: Consent.

3.3.3 Data Collection/Reporting

Minimum Practice

There is evidence to show that the organisation:

- ☐ can quantify its referral work (referrals in and referrals out) and reports referral work as service delivery.

3.4 Financial Access

The organisation recognised that fee for service creates a barrier to accessing services for people who have experienced sexual assault and therefore sexual assault services should continue to be free of charge.

3.5 Use of Interpreters

The use of interpreters can increase access to services, and improve the service's understanding of client needs and issues.

Need for an interpreter may arise in situations of increased stress such as appearance in court. The organisation recognises that interpreting is a sophisticated skill, and that client autonomy may be undermined when a family member or friend of the client is used for interpreting. In order to mitigate associated risks the organisation:

- ☐ should have policies and procedures in place regarding use of interpreters
- ☐ should provide training to all staff members in working with interpreters
- ☐ should inform clients of their right to, and the availability of, interpreters.

3.6 Client Advocacy

The organisation recognises its role in client advocacy and the role of other advocacy services, or appointed advocates, in promoting the needs of a particular client or client group, particularly those with multiple or complex needs, children or those with a disability.

Minimum Practice

There is evidence to show that the organisation:

- ☐ has knowledge of advocacy services that may be of benefit to its client group/s
- ☐ informs clients of their right to, and the availability of, client advocates
- ☐ should ensure written client consent as a pre-requisite for advocacy work undertaken by the service, and for working with externally appointed client advocates

- ☐ should ensure procedures are in place to maintain client privacy and confidentiality and safety when working as an advocate or with advocates
- ☐ should have policies and procedures which support practitioners in their advocacy work
- ☐ should provide opportunity for professional development in advocacy
- ☐ should be able to quantify and describe its advocacy work.

Section 4: Client Engagement

Responding to Crisis

Traumatic responses to sexual assault can be complex, varied and ongoing, potentially for months and years, as well as presenting in stages. The assault may be very recent (acute), or have occurred in the middle or distant past, or there may have been assaults over a period of time by the same or a number of offenders. Sexual Assault services recognise that victims of sexual assault have been subjected to dominating forces of power and control by the perpetrator, and may have been experiencing severe subjugation.

The term 'crisis intervention' often refers to responses to recent assault, and use of the term 'in crisis', particularly by forensic or justice systems, often refers to those whose traumatic event is recent. This is pertinent to the short time-frame in which forensic (police and medical) evidence can be gathered. It is also relevant for the symptoms of Acute Stress Disorder, which are experienced in a brief window of time after the traumatic event has occurred.

Restricting use of the term 'in crisis' as above can under-estimate the impact of persistent trauma responses for those whose assault was a longer time ago, including in childhood and for those who have suffered multiple sexual assaults. The impact of community views and beliefs in relation to sexual assault and those who experience it, can affect the person's decisions and timing in relation to seeking assistance.

When someone who has experienced sexual assault makes the decision to access support services it is entirely individualised and uniquely personal. A negative or even apparently doubtful or questioning response to a first disclosure can contribute to the impact of the trauma. This decision to come forward may be made after long reflection on the impacts of the sexual assault; at the realisation of 'I cannot keep going on like this, I need to do something'; or in response to any other of a wide range of triggers. It is the experience of sexual assault services, that relatively few victims access services immediately after or even soon after the event.

Also, there are often many, and complex, barriers to accessing sexual assault services. The person may feel overwhelmed at the prospect of making changes, or they may blame themselves. Coming forward to seek support may pose many significant risks such as potential loss of relationships, safety risks, financial security, loss of accommodation, sense of identity, and so on. In the case of family violence, the violence often escalates at this point.

Thus, the decision to come forward and seek support for sexual assault is a hugely courageous one. It can be very frightening, and may be experienced as a crisis in itself. Prior to making contact with sexual assault services, the person often seeks a variety of other supports, for example, such as relaxation groups, general counselling, depression support and so on.

These standards recognise that a victim-client may be in 'crisis' at any point in their journey of recovery, at recurring points, when triggered by certain events, and at initial contact with a sexual assault service, whenever that may be.

A client centred model of care, therefore, is one which responds appropriately to the client at initial contact, regardless of how recent or long ago the sexual assault occurred.

Ensuring Safety

In accordance with the trauma model (see Introduction), establishing safety for the client must occur first. The resources and time required for this will depend on the client's particular circumstances, the complexity of their issues, any existing co-morbidities andtheir support networks.

A thorough risk assessment is required to determine safety needs. Some clients may be at risk from suicide, self harm, homelessness, substance abuse, financial distress and so on. Marginalised clients and those with inadequate social supports can also be at additional risk. The level of advocacy required to establish client safety may be a significant and a long term component of service delivery for new clients, and also re-occurring for existing longer-term clients.

Health, Forensic Medical, Police & Legal Services

Clients of a recent assault should be made aware of their right to access police, forensic medical care and legal services.

The organisation has an important role in assisting the client to navigate these services and ensure that the process is as sensitive and responsive to their needs as possible. All organisations will benefit from having a good working relationship with these associated support services. Many states/territories have interagency and acute care guidelines for police and forensic medical services. Sexual assault services will be aware of and work in accordance with any such protocols.

Case management may be required for some clients and the sexual assault service may have a role in identifying a case manager, if they do not have capacity to provide that role themselves.

All sexual assault clients should be provided with information about reporting the crime they have experienced to Police.

4.1 Initial Contact

In recognising that clients may be in crisis, the response at initial contact will be provided by appropriately trained professionals who are able to ensure that entry into the service is therapeutically oriented, sensitive, supportive, and where each new client is provided with equal promptness.

Depending on how the organisation is structured, the first person a new client speaks with may not be a qualified counsellor. For the purposes of these standards, the position for responding to the initial contact shall be referred to as 'Front Desk Worker'. In some organisations this position may also provide the Intake function, while in others the functions may be separated into two roles. To cater for this possibility, these two roles have been treated separately in these standards.

4.1.1 Non Service Delivery Staff

Minimum Practice

There is evidence to show that:

- ☐ every employee whose role is not direct service delivery is provided with basic training in sexual assault service, including procedures they are expected to follow if and when they receive the initial contact.

4.1.2 Front Desk Worker

Minimum Practice

There is evidence to show that the organisation:

- ☐ acknowledges the service delivery elements in the role of front desk worker
- ☐ Provides training in the field of sexual assault service delivery to the front desk worker
- ☐ has protocols to guide the Front Desk Worker in responding to victims of sexual assault
- ☐ recognises the unique worker health and safety hazards for front desk workers and has strategies to reduce and respond to them.

4.2 Acute Care: Responding to Recent Assault

Acute care refers to the response required for a very recent victim of sexual assault, including establishment of immediate safety.

The organisation has procedures in place to ensure that victims of recent sexual assault receive the acute care services they need which may include: medical care, medical-forensic services, police involvement, legal services.

The organisation has a duty of care to assist clients of recent assault in accessing ongoing supports and services particular to their needs.

4.2.1 Legislation Regarding First Disclosure

Minimum Practice

There is evidence to show that the organisation:

- ☐ is familiar with its relevant state/territory laws concerning first disclosure and has systems in place to ensure that their service delivery model supports the legal processes
- ☐ ensures all staff members are aware of first disclosure obligations and implications
- ☐ ensures note taking is sufficient to meet first disclosure legal requirements.

4.2.2 Medical, Police, Forensic Support

Minimum Practice

There is evidence to show that the organisation::

- ☐ is familiar with and abides by any existing interagency guidelines with respect to police, medical, legal or forensic services
- ☐ has developed an agreed framework/memorandum of understanding with the respective agencies
- ☐ informs all clients of their legal rights to medical, forensic, police and legal services (clients understand they will be supported in their decisions)
- ☐ enables access to acute medical care, immediate safety and support is prioritised over administrative procedures of intake (See Section 4.3)
- ☐ enables clients access to interpreter and/or support person of their choice is prioritised
- ☐ provides clients with written and /or verbal information on the various procedures including:
    - the staff member that may be involved in the medical, forensic and police procedures and their roles
    - the nature of the procedures, what will happen, when and why
    - their right to not give or withdraw consent to any process at any stage.
- ☐ ensures efforts are taken to contact a support person of the client's choice
- ☐ ensures, where the client is a child or young person (and there is no conflict with mandatory reporting requirements), or appears to have an

intellectual disability, and is on their own, the provision of care will be prioritised, while attempts are made to identify and locate a trusted and independent third person

- ☐ ensures information about any forensic procedures, support services or therapy will be provided in a developmentally appropriate way to enable the client to participate in informed consent as fully as possible.

4.2.3 Client Advocacy

Minimum Practice

There is evidence to show that the organisation:

- ☐ has a policy and procedures to guide staff members in providing client advocacy services
- ☐ ensures clients are offered assistance to contact a support person of their choice to be with them through any medical, police, legal or forensic procedures
- ☐ takes steps to respond appropriately to, and in accordance with, the client's cultural, social, religious, language and other individual needs
- ☐ ensures procedures are in place to ensure mandatory reporting obligations are fulfilled (See Section 8: Child Protection)
- ☐ ensures clients are provided with information, referral and advocacy, as appropriate, to access victim support services.

Best Practice

There is evidence to show that:

- ☐ staff members have access to training and development in client advocacy
- ☐ the organisation takes opportunities to contribute to medical, police, forensic and legal profession's knowledge and understanding of the trauma impacts of sexual assault.
- ☐ where the client has impaired capacity, efforts are made to coordinate or 'case manage' instances of multiple service provision.

4.2.4 Ongoing Follow up and Safety

Minimum Practice

There is evidence to show that:

- ☐ all clients of recent assault are offered access to follow up counselling, information about 24 hour telephone sexual assault services, and other relevant support services
- ☐ a comprehensive assessment of ongoing risk and needs is undertaken
- ☐ the organisation will take steps to assist the client in accessing any of the services needed.

4.3 Intake

The purpose of Intake is to gain an overview of the client's presenting issues and transition them into the organisation for further services. If the service is unable to meet the client's needs efforts are taken to access alternate services.

Where appropriate at initial contact, the intake process may be rearranged to ensure that access to medical/police/forensic assistance is prioritised over the service's formal intake procedures.

Minimum Practice

There is evidence to show that:

- ☐ intake is provided by workers who have training and expertise in sexual assault service delivery
- ☐ consent to participate in the intake process is gained
- ☐ intake procedures include enquiries about any children who may be impacted/involved (See Section 8: Child Protection)
- ☐ data collection systems are in place to adequately identify and describe the client groups (for example demographic, cultural information)
- ☐ intake procedures are comprehensive enough to match the client with the appropriate service and practitioner
- ☐ intake records form part of the client file.

Best Practice

There is evidence to show that:

- ☐ intake is conducted by qualified counsellors with additional training in sexual assault service delivery.

4.4 Wait List Management

When those who have experienced sexual assault contact the organisation for support they will ideally receive access to services in a time frame of their choosing. This recognises that the contact is often made at a point of crisis, and that prompt service is both validating and instrumental to the recovery process.

As demand for service can outstrip available resources, sexual assault services will have a wait list management system in place to support the client until the required service is available. This would typically include periodic contact with the client for symptom management, referral to local private practitioners for symptom management, and referral to a 24 hour sexual assault telephone counselling service.

Organisations may benefit from developing an integrated feedback system linking initial contact with assessment, intake, therapeutic planning, client progress with exit planning and wait list management strategies.

Minimum Practice

There is evidence to show that:

- ☐ the organisation has a wait list management policy and protocols which aimed to meet the needs of clients
- ☐ if available, the client will be offered choices of appropriate alternate agencies/services that could assist more quickly (See Referrals, Section 3.3 above)
- ☐ consent from the client to be on the wait list including all aspects of wait-list management will be sought and recorded
- ☐ organisations are actively pursuing strategies to reduce wait times for services
- ☐ effectiveness of wait-list management procedures will be reviewed regularly
- ☐

Best Practice

There is evidence to show that:

- ☐ organisations undertake advocacy for additional resources to reduce wait list times.

Section 5: Therapeutic Interventions

The organisation's purpose and funding agreement/s and/or business plan will determine the complexity of trauma it can assist with.

Client and context

The psychological trauma of sexual assault is well-articulated by experts in the field. The complexity and duration of the trauma is influenced by many aspects, including the severity, extent and duration of the abuse, the relationship with the abuser and social supports around the victim at the time (See Section iii Trauma Model).

These standards recognise that those who have experienced sexual assault may experience their trauma within the context of dominant social culture, such as inequitable gender relations, community views of sexual assault, or racial relations. Gender stereotypes and societal constructs around femininity and masculinity will influence how women and men experience their trauma; if, how and when they seek support; and the content of the discussions in counselling.

Sexual abuse of children has serious psychological consequences arising out of deep violation of trusting relationships, extreme abuse of power and domination, misattribution of responsibility, interruption of psychological and emotional development.

Many other contextual factors can impact on how the assault is experienced and how it will be made 'sense of' for the client.

Range of Therapeutic Supports

The complexity of trauma and how it is experienced and expressed by different client groups has required the development of multiple 'expertise' within the sexual assault service sector.

Services and individual practitioners undertake ongoing study, learning and reflection on the impacts and experiences of sexual assault of their particular client group/s. Depending on the needs and situation of each client therapeutic support may include a mix of:

Counselling, therapeutic group work, client advocacy

- *Education and awareness raising*
- *Networking, referral and case coordination*
- *Working in coordination with forensic medical services, legal services, the police, health, other government and non government agencies*
- *Working therapeutically within family systems, and addressing a potentially wide range of connected issues such as substance misuse, homelessness, anxiety, depression, self harming behaviours, suicide ideation, family violence, parenting issues.*

What Works?

Evidence shows that an integration of Cognitive, Narrative, and Acceptance and Commitment Therapy (ACT), psycho social interventions, Multi Modal Therapy, counselling practice is effective in trauma therapy, Principles of therapeutic interventions that are central to trauma work are summarised:

- *provide and ensure safety - the client must feel and perceive that they are safe; emotionally safe with the counsellor, and more broadly in their current life situation*
- *provide and ensure stability - the client is not overwhelmed and has the capacity to resist or manage disruptive stimuli and stress*
- *there is a positive and consistent therapeutic relationship which is able to support the client through the rigours of therapy*
- *the therapeutic interventions are flexible and tailored to meet the specific characteristics of each client*
- *gender issues must be taken into account - male and female experiences and processing of sexual assault is shaped by gender roles and social expectations*
- *take account of socio-cultural issues - socio-economic status, culture, and ethnicity and how they may translate into experience and presentation; and even expectations of counselling/therapy*
- *monitor and control countertransference as it may have a harmful effect on the client and disrupt the therapeutic process.*

(Briere, J, Scott, C. 2006 pp 70-84)

The choice and effectiveness of any therapeutic interventions will also be determined by:

- *the priorities of the client, or goals for counselling, and the client's preferred way of working*
- *the extent and complexity of the trauma,*
- *available duration of support, i.e. short, medium or long term therapy*
- *Short, Medium or Long Term Counselling*

The duration of counselling support required will depend on the complexity of the trauma, the level of general functioning of the client, and supports they have.

Adult who experienced sexual assault in childhood may suffer symptoms of complex trauma. Complex issues may also be evident in adults who have experienced repeated or multi-traumas or who have high levels of disadvantage and/or a range of other needs. Working with complex, high needs clients usually calls for long term support, over months, and sometimes years.

Services restricted to short or medium term counselling may be able to assist high needs clients with symptom management, or in dealing with other life issues that may be impacted by the trauma, but not the trauma itself. Support can also be given through advocacy and referral to other appropriate services.

Informed Practice

The organisation recognises that clients are investing effort, time, and resources in their recovery and placing their trust in the effectiveness of the interventions suggested by the practitioner.

The sector promotes the need for accountability to clients, funding bodies, and the community, for the effectiveness of therapeutic interventions in achieving positive outcomes.

However, it is acknowledged that measuring client outcomes and effectiveness of interventions poses several challenges. Firstly, client recovery is not linear, and may extend beyond the period of the relationship. Secondly, there is potential bias and shortcomings in relying on practitioner-client review sessions alone. There are limited peer-reviewed randomised controlled trials for effectiveness of counselling interventions on trauma. Further, it cannot be assumed that an intervention clinically proven to be successful with one client group experiencing a certain set of 'symptoms' will achieve the same results with a different client group.

Given these challenges, NASASV recommends that evidence of the effectiveness of counselling methods should be derived from a combination of sources including:

- *client based review and feedback sessions*
- *review of emerging evidence in the literature*
- *reflective practice*
- *outcome evaluation methods suitable to the counselling modality and is client focused.*

5.1 Individual Counselling

The counselling interventions used are informed by trauma theory and evidence based practice that recognises that sexual assault is a gendered crime.

Clients, new and existing, may present in crisis at any or several points on their journey and the therapeutic response is appropriately flexible to meet changing client needs. See Section 4: Client Engagement.

Counselling interventions are appropriately matched to client need, service capacity and informed by evaluation feedback.

5.1.1 Organisation Systems

Minimum Practice

There is evidence to show that the organisation:

- ☐ utilises therapeutic models, services and programs which are informed by trauma research and practice
- ☐ can clearly articulate the client groups and complexity of trauma it is resourced to assist
- ☐ Utilises therapeutic models which are appropriate to the complexity of the trauma, level of client needs and service capacity
- ☐ employs practitioners who have the skills to provide the therapeutic interventions and clearly articulates its practice in practitioner orientation
- ☐ informs client of their rights and responsibilities including terms of service, policies and procedures around confidentiality and consent
- ☐ can clearly articulate the scope of supports it is resourced to provide (e.g. counselling, groups, advocacy, case management, court support, etc.)
- ☐ allocates resources to the ongoing professional development of the therapeutic team relevant to client groups, client issues and service programs
- ☐ has an integrated framework for coordinating intake, assessment, wait list management, counselling, evaluation and exit.

Best Practice

There is evidence to show that the organisation:

- ☐ implements a range of therapeutic evaluations, including objective progress review and evidence based evaluations.

5.1.2 Assessment & Allocation

Minimum Practice

There is evidence to show that:

- ☐ there is an assessment framework designed to enable identification of presenting needs, risk to client safety, any dependent children and that can respond to changing or emerging needs as they arise
- ☐ the assessment process contributes to appropriate allocation of client to therapeutic program and counsellor
- ☐ the client is informed about their right to request an alternate practitioner – either within the service or through referral to an external agency.

5.1.3 Therapeutic Process

Minimum Practice

There is evidence to show that:

- ☐ a therapeutic plan, including goals for counselling, are established with the client as early in the therapeutic process as practicable
- ☐ goals for counselling are appropriate to the expected length of service (i.e. short, medium, long term counselling)
- ☐ framework for evaluation and review is included as part of goal establishment
- ☐ the therapeutic techniques are discussed with client and client focus
- ☐ interventions used are documented and reviewed regularly with the client
- ☐ individual practitioners are able to identify the counselling interventions they use with each client, and why
- ☐ interventions used are considered most appropriate for, and tailored to, the specific needs of each client.

5.1.4 Child or Young Clients

Minimum Practice

There is evidence to show that:

- ☐ the organisation has policies and procedures in place to ensure their duty of care in promoting the safety and wellbeing of child and young clients
- ☐ if the client presents with an/other adult, and if the practitioner considers it necessary/appropriate, they will seek consent from the client to allocate some of the session time to consult with them without the presence of their adult companion.

- ☐ the practitioners working with children have undertaken relevant professional development in child psychology/counselling.

5.1.5 Counselling Evaluation

Minimum Practice

There is evidence to show that:

- ☐ the service has a clear and articulated evaluation model which uses a range of evaluation methods
- ☐ therapeutic evaluations inform goal review and therapeutic planning with the client
- ☐ therapeutic progress is explored in clinical supervision
- ☐ counselling clients are given opportunity to provide anonymous feedback of service and counsellor satisfaction
- ☐ there is a quality assurance schedule for file review and audit, and that it is carried out by qualified and objective personnel.

Best Practice

There is evidence to show that:

- ☐ the evaluation framework includes use of an evidence based evaluation tool appropriate to the therapeutic interventions used
- ☐ the evaluation framework enables collated reporting across the service
- ☐ the therapeutic review and evaluation model is integrated with and informs intake and allocation processes
- ☐ file audits are undertaken by appropriately qualified personnel

5.2 Therapeutic / Support Groups

Therapeutic/support groups can be of benefit to clients who have experienced sexual assault, particularly adult survivors of childhood sexual assault.

Minimum Practice

There is evidence to show that:

- ☐ group programs are informed by trauma theory and are evidenced to be beneficial to participants
- ☐ groups are facilitated by qualified sexual assault counsellors who have group facilitation skills
- ☐ group processes are conducted in accordance with the principles of adult education
- ☐ sufficient intake and assessment procedures are in place to ensure that participation in the group is appropriate for the client's needs

- ☐ group participants are aware of their rights and responsibilities of participation, including confidentiality, consent, terms of service
- ☐ written consent to participate is received from each participant
- ☐ procedures are in place to follow up on the safety and well-being of group participants during and between group sessions
- ☐ participants are provided with opportunity to evaluate the group processes and outcomes
- ☐ where the client is participating in counselling and group work concurrently there are clear guidelines in relation to confidentiality and consultation between practitioners.

Section 6: Consent

The process of consent sits best within the context of a relationship with a service professional/practitioner, where it can be accompanied by discussion with the client. Consent for services begins with initial contact/intake and is progressed through subsequent therapeutic interventions or support services.

There are two fundamental components of informed consent: (1) the person has the capacity to give consent voluntarily and without interference from others, and (2) the level of information supplied is sufficient to enable an informed decision.

Capacity to Consent

Capacity to consent requires that the client is capable of understanding in broad terms what is proposed. The client must be able to understand the information; weigh up the pros and cons of options; assess any risks or consequences; consider any viable alternatives; and be able to communicate their decision. Silence, or no response, should not be taken as consent. Similarly, disagreement or refusal should not be taken as an indication that the client has not properly understood the information.

Organisations will respect the autonomy of clients to show hesitation, disagree with or not consent to a particular intervention or aspect of service delivery (such as pace, answering questions, doing 'homework', making referrals, and the like). Practitioners should also be alert to the possibility that a client gives consent to satisfy the wishes/recommendations of the practitioner or because they lack the confidence to clearly assert themselves. A pre-existing medical diagnosis, condition or disability can inform the process of considering capacity to consent, however the practitioner must be careful not to jump to conclusions or make un-tested assumption about the client's capacity based solely on knowledge of a pre-existing condition.

A heightened state of stress, and certainly trauma, can adversely impact on an individual's ability to clearly consider all aspects of the issue under question. In such situations only the most essential questions of consent should be considered at that time. Ideally, the client will also be provided with opportunity to review their decision at a later time. More time should be afforded for consideration and review of more significant decisions.

The laws in relation to consent to health care vary across different states and territories, as do laws in relation to consent to sex and mandatory reporting. In general, Australian law recognises that adults (18 yrs +) have the legal capacity to consent to health care, and that prior to this the child/young person's parent/legal guardian has rights in the consent process for health care. However, this is not absolute and it is recognised that children have the right to participate in the process and become increasingly competent to give independent consent as they mature. Each service must be aware of the law operating in their state/territory.

Informed Consent

Gaining informed consent is fundamental to restoration of power and decision making to clients. Informed consent emphasises and develops the client's sense of self efficacy, de-mystifies the process and can reduce any anxiety about what the process is likely to entail. It is also critical to ensuring that the proposed service or intervention is appropriately matched and paced to the experience and needs as identified by the client.

For the consent to be informed clients must be given accurate, up-to-date information in a manner they can understand. The information will cover the nature of the service, how it is relevant to the client's goals and any alternatives. Benefits and potential risks or consequences must be fully explored. Providing sufficient and transparent information is the duty of care of the practitioner.

Some counselling/therapeutic interventions or services will make greater demand for client input for the intervention to be effective. The more conditional the intervention, the greater the need to discuss with the client what may be expected of them, and what they may experience in the process.

Evolving Consent

Each client will be presented with sufficient information to make informed consent as early as possible in the process and at each decision point.

For those who are very recent victims of sexual assault the prioritised aspects of consent are in relation to accessing medical, forensic, police support, confidentiality and its legal exclusions, and if the service has any non-negotiable conditions.

For counselling clients, the process of consent will be evolving. It may take some time for the client's issues to be fully understood. It may be better to begin the therapeutic relationship and build the consent for counselling goals, expected number of sessions, therapeutic methods, over the following session/s.

Client needs and priorities may also change over time according to what they're experiencing and call for modifications to any previously agreed goals or processes.

Clients who appear in a state of high stress, trauma or crisis should be afforded more time and support in decision making. Services and practitioners should be mindful that any consent given at the time of crisis, may be withdrawn or changed at a later time. Likewise, more time should be provided for decision making about more significant issues.

Children and Young People and Consent for Medical Care

Some states have legislation that deals with age of consent for medical care, including forensic/medical treatment in cases of recent assault. Each service is obliged to be familiar with their state/territory laws.

In the absence of a state law, common law prevails. Common law for judging capacity to consent to medical care was established in a legal case in the UK in 1986[1] *and the test is now referred to as 'Gillick Competency'. It was subsequently approved by the Australian High Court in 1992 and considers the following:*

- *the age, attitude, maturity of the client, including their physical and emotional development;*
- *the client's level of intelligence and education.*
- *the client's social circumstances and social history;*
- *the nature of the client's condition;*
- *the complexity of the proposed healthcare, including the need for follow up or supervision;*

[1] *Gillick v West Norfolk and Wisbech Area Health Authority* [1985] 3 All ER 402

- *the seriousness of the risks associated;*
- *the consequences if the client does not have the care;*
- *there the consequences of receiving the healthcare include death or permanent disability, that the client understands the permanency of this and the profound nature of the decision he or she is making.*

(Source: QLD Health, 2011, p 40)

Overall the young person's capacity to consent increases as he/she moves toward adulthood. In the meantime, the parent/guardian also holds concurrent rights of consent on behalf of the child/young person which diminishes as the child matures.

Young People and Consent for Counselling

There is less clarity around application of consent laws to counselling. However, the factors of the Gillick test may be helpful. Additional time should be taken to slow down the process, possibly using communication aides, the assistance of a trusted adult, or advocate in order to ensure the client remains at the centre of decision making.

If a child or young person presents on their own and is able to show sufficient maturity and understanding to make their own decisions, services must consider their duty of care to assist the child or young person while encouraging them to seek the support of a parent/carer or trusted adult.

Where there is uncertainty about the young client's competency their involvement in the decision making is still paramount and practitioners should do everything possible to ensure their voice is heard.

Conflict and Complexity

Navigating through consent becomes more complex when parents/guardians and the child or young person have conflicting views about the best interests of the child/young person and the rights of the child/young person. This can become evident around decisions to access counselling, forensic examinations, legal action or when family law matters are present. Services should be sensitive to the possibility that conflicts of interests between parents/guardians and the child/young person could undermine the adult's ability to exercise consent without bias. This is a complex area of law and specific guidance in these matters is outside the scope of this document, except to say that the instructions and wishes of the child/young person and the respect for their human rights must remain paramount. Where such conflicts arise and practitioners are concerned that the voice of the child/young person may be getting lost, they should seek advice of specialised children's legal service or advocate.

NOTE: nothing in the above section should be used to restrict or reduce the practitioner's obligations for duty of care. Where it is assessed that seeking consent to act on duty of care will not place the person in further danger, practitioners should seek their client's consent to act on duty of care matters, and seek their client's participation in that process.

For further information regarding consent associated with information sharing see ***Section 7: Confidentiality.***

6.1 Organisation Framework

The organisation recognises that consent is not a 'one size fits all' process and has a comprehensive and flexible system to ensure that each client is fully engaged in the consent process, from initial contact through to file closure.

Minimum Practice

There is evidence to show that the organisation:

- ☐ is aware of, and has practices consistent with their state/territory consent legislation
- ☐ has policies and procedures are consistent with the National Privacy Act (1998) and any subsequent amendments and any state/territory health records legislation and regulations
- ☐ has clear and rigorous policies and procedures to guide the consent process for all staff with client contact
- ☐ policies and practices respect the evolving and changing nature of consent and that it is time-limited
- ☐ has resources to assist and support information sharing between the practitioner and clients with differing language, culture, age, and capacity.

Best Practice

There is evidence to show that:

- ☐ the subject of consent and its related issues of ethics, confidentiality, considerations for minors and those with impaired cognitive function are periodically included in professional development activities.

6.2 Counselling Consent

Commitment to an ongoing process of informed consent is central to a strong therapeutic relationship based on mutual respect, collaboration, trust and the pursuit of equality between practitioner and client.

Minimum Practice

There is evidence to show that:

- ☐ informed consent forms part of establishing therapeutic goals and is ongoing throughout the counselling process
- ☐ confidentiality and its limits/exclusions are explained to the client
- ☐ any possible/likely adverse effects or consequences of the intervention are explained
- ☐ receiving written client consent is a condition for consulting with other involved professionals; and that in the written consent the content of the information exchanged is explicit and time-limited

- ☐ where there is doubt about the client's level of literacy or proficiency with the language used the practitioner reads any consent related documentation and provides further explanation using terms and examples that may help in understanding
- ☐ the client is informed about how they may make complaints/give feedback
- ☐ for adults with cognitive impairment that may undermine capacity, the assistance of a trusted adult or advocate is sought
- ☐ any matters of consent given verbally are recorded as such in the counselling file.

Best Practice

There is evidence to show that:

- ☐ there are systems in place for counsellors to seek supervision about gaining informed consent

6.2.1 Children and Young People

Minimum Practice

There is evidence to show that:

- ☐ the practitioner modifies their informing process to ensure, as much as possible, that the delivery is age/developmentally appropriate
- ☐ the practitioner will carefully document the process and any tools used throughout the consent procedures, including their own judgement regarding the client's capacity to understand and make decisions
- ☐ if the client does not wish to involve a parent/guardian or other trusted adult, the reasons for this will be explored, and efforts taken to involve an alternate trusted adult
- ☐ the organisation has procedures in place for responding to instances of consent related conflict between parents/guardian and the child/young person
- ☐ any matters of consent given verbally are recorded as such in the client file.

Section 7: Client Privacy and Confidentiality

A client's right to confidentiality is fundamental to the provision of sexual assault services and is a key factor in providing a safe space for those who have experienced sexual violence to seek support.

Confidentiality must be assured in all aspects of the service from initial contact to file closure, including the physical spaces used in service delivery, and the storage and access of client data and client files.

The National Privacy Act (1988) provides a sound baseline for privacy with respect to information collection and states that only information necessary to carry out the purpose of the organisation will be collected; consent is a requirement for information collection, and the client is entitled to know why the information is collected and how it will be used. Following are some useful definitions:

***Personal Information** means information or an opinion (including information or an opinion forming part of a database), whether true or not, and whether recorded in a material form or not, about an individual whose identity is apparent, or can reasonably be ascertained, from the information or opinion (National Privacy Act 1988).*

***Sensitive Information** means information or an opinion about an individual's: racial or ethnic origin; or political opinions; or membership of a political association; or religious beliefs or affiliations; or philosophical beliefs; or membership of a professional or trade association; or membership of a trade union; or sexual preferences or practices; or criminal record; or health information about an individual; or genetic information about an individual that is not otherwise health information (National Privacy Act 1988).*

***Health information** includes any information collected about the client's health or disability, and service provision including notes of symptoms or diagnosis and the treatment/intervention provided; reports and results; appointment and billing details; medical or dental records; prescriptions and the like; any other information about the client's race, sexuality or religion (Office of the Australian Information Commissioner).*

Thus confidentiality in all aspects of service provision must be protected. State or Territory health records legislation may also apply to sexual assault services and organisations will ensure that they comply with any relevant provisions contained therein.

Duty of Care

The practitioner must describe the exclusions relating to duty of care when informing the client about confidentiality and privacy. Organisations and practitioners are obliged to be familiar with and comply with any mandatory reporting legislation in their state/territory.

Consultation with Other Services

Sexual assault services and practitioners are encouraged to build positive working relationships with other organisations that may be able to assist clients. This is an important aspect of providing holistic care and advocacy for individual clients. Practitioners must, however, prioritise client trust and confidentiality of their information over the building of the relationship with other services. Any client

information shared with another agency/practitioner must be limited to that which is relevant and consented to in writing by the client. Further, the information the client consents to share with one agency does not automatically extend to another agency. As with consent to service delivery, consent to share information is specific, and may evolve and change over time according to context or situation. Such changes will require additional written consent.

Children and Young People

If a young person is able to consent to service, then they also have the right to expect privacy and confidentiality of their health information/client file. This is a complex issue, particularly with reference to young people who sought the services independent of a parent/carer and where that parent/carer is seeking access to that young person's file/information. In these cases the organisation upholds its duty of care to the client to provide assistance and support and continue working with the young person to identify what level of information the young person agrees to have disclosed to their parent/carer. Services may be advised to seek legal advice on a case by case basis. See also ***Section 6: Consent****.*

Privacy in the Community

Organisations will be sensitive to client privacy in community settings. Organisations may consider providing service/appointments outside normal hours or as outreach, as an additional measure to protect client confidentiality. (See Section 3: Increasing Access).

7.1 Organisational Framework

The organisation provides a comprehensive framework to protect the confidentiality of client information.

Minimum Practice

There is evidence to show that the organisation:

- ☐ is aware of, and has practices consistent with their state/territory health records and information/privacy legislation; and mandatory reporting legislation
- ☐ has policies and procedures in place to protect client information, including procedures for dealing with breaches of client information
- ☐ Informs all staff members regarding the policies and procedures and how they apply to their own roles.

7.2 Client Rights and Responsibilities

Minimum Practice

There is evidence to show that:

- ☐ clients and visitors are made aware of the organisation's Privacy and Confidentiality policy
- ☐ the organisation provides written and verbal information to all clients regarding confidentiality as applicable to them, including exclusions
- ☐ clients are informed of the reasons for requesting their personal details, how they are stored and how their information may be used (See **Section 9: Client Records**)
- ☐ the organisation has policies and procedures in place for managing client requests to access their own file. (See **Section 9: Client Records**)

7.3 Sharing Information

Minimum Practice

There is evidence to show that the organisation:

- ☐ has policies and practices around information sharing are consistent with the National Privacy Act 1988, any state/territory health records legislation, state/territory child protection related legislation
- ☐ seeks 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
- ☐ ensures the scope of consultation and content of information consented to be shared is specific, time-limited and reviewed with the client

- ☐ will inform the client 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)
- ☐ policies prohibit employees from discussing clients or client cases in public / waiting spaces and with those not in a 'need to know' position
- ☐ Ensures practitioners will 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.

7.4 Physical Spaces

Minimum Practice

There is evidence to show that:

- ☐ physical spaces where client engagement occurs afford an appropriate level of privacy from being overheard, and that all client-related information is protected from observation by passers-by.
- ☐ waiting areas are arranged to afford individuals a sense of privacy and mitigate re-traumatisation.

Section 8: Child Protection

As children and young people have vulnerabilities by virtue of their age and dependency, services with adult clients may need, from time to time, to extend their duty of care beyond their adult client to any dependent children. Sexual assault services need to be aware if the client has parenting responsibilities and this should be included in client intake/assessment.

Practitioners should have up to date knowledge and understanding of issues relevant to child wellbeing including child development and attachment theory, the different types of abuse and neglect and how they may present in children, awareness of the diversity in family systems and values around child rearing across a range of relevant cultural groups, as well as protective factors.

A practitioner's view of child wellbeing and risk of harm will be influenced by the practitioner's own culture and values system and their perception of the context or situation of the family environment. Service delivery will benefit from practitioner's ongoing learning around diverse family systems across a range of cultural and minority groups.

Child protection activities are best carried out within the context of therapeutic service delivery where there can be a sensitive, comprehensive, reflective and ongoing approach to assessing risk of harm and protective factors in place, and how best to strengthen those in the context of their family, their community, any mandatory reporting requirements, family law proceedings and so on.

It is well documented that women and men who have experienced childhood sexual abuse have a greater vulnerability to further sexual assault in adulthood. Trauma from childhood sexual abuse and adult sexual assault can impact on a person's capacity to function; which may make parenting more challenging.

Services will be aware that clients with complex trauma are more likely to also experience mental health issues, have substance abuse issues, be homeless and at higher risk of repeat assault; all of which can have flow on impacts on dependent children.

The challenges in engaging and supporting clients in trauma are heightened when children are involved and at risk. Sexual assault services should incorporate assessment of risks to children into the process of establishing relationship with the client and incorporate protection of children into client therapeutic goals. Assessment should highlight family competencies, strengths and resources that can be built on and utilised for the wellbeing of the client and their child/ren. This assessment and action process will be ongoing and evolving as the therapeutic relationship develops and work with the client progresses.

As with adult clients in crisis, activities in child protection will often extend beyond mandatory reporting requirements and parenting support into the broader arena of establishing safety, such as being free from family violence, having safe and secure accommodation, access to financial resources and links to other social supports and services. Practitioners will explore support options with the client and should have current knowledge of services that could assist the client with parenting and establishing safety as well as specific services for children. This will call for close inter-agency collaboration, comprehensive referral systems, robust client consent

procedures for sharing information and very clear communication with clients around confidentiality.

The client must remain at the centre of these efforts, reinforcing the importance of developing and maintaining a trusting and transparent working partnership between client and practitioner, whilst simultaneously upholding child protection as a priority. Efforts to protect children should identify and build on the strengths and resources of the parent/family and be undertaken in partnership with, and in support of, the adult client's parenting capacity. It should be clear and obvious to the client that the service is working for them, and with them, for their children.

Therapeutic work in this field can be complex and require reasonably long term engagement with clients to maximise positive outcomes for client and child/ren.

A collaborative approach is crucial for achieving positive outcomes for vulnerable children. No single practitioner or agency has all of the skills or resources required to meet the needs of all clients on their journey of recovery from trauma and *protect any children. Organisations must be able to realistically assess their capacity in this area, and develop strategies to address client needs they are unable to meet.*

Practitioners who have any concerns about a child or their assessment of risk are advised to consult with their colleagues/supervisor.

8.1 Organisation Response

Strengthening the capacity of the parent/guardian/carer to function well and drawing on resources and supports within their local community will be key in establishing safety and security for both the client and any dependent children. This work occurs best in the context of therapeutic relationships and may be ongoing and evolving.

Minimum Practice

There is evidence to show that the organisation:

- ☐ is familiar with and abides by the child protection laws and regulations in its state/territory
- ☐ is familiar with, and works in accordance with, any child protection interagency guidelines in its state/territory
- ☐ ensures child protection policy and practices recognise the complexity of issues relevant to child safety and wellbeing
- ☐ can articulate in practical terms how it contributes to strengths based child protection responses
- ☐ 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
- ☐ policies cover child protection exclusions regarding privacy, confidentiality and consent. (See **Section 7: Confidentiality**).

Best Practice

There is evidence to show that the organisation:

- ☐ 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
- ☐ takes an advocacy approach when working with clients and children who have child protection concerns.

8.2 Practitioner Response

The establishment of client focused, strengths based, trusting and transparent relationships are necessary to successfully integrate child protection strategies into therapeutic work with clients who have experienced sexual assault/abuse.

8.2.1 Adult Clients

Minimum Practice

There is evidence to show that:

- ☐ history taking with new clients enquires into the existence of any children, their wellbeing and associated parenting issues
- ☐ the practitioner can articulate how he/she integrates strengths based child protection practices into their work with clients
- ☐ the practitioner discusses with the client their obligations under mandatory reporting laws and, when required, ways that notifications can be made in partnership with the client
- ☐ the practitioner has knowledge of and referral pathways with a range of services that can provide additional support to clients and any children
- ☐ information will be provided, and support services offered, to the non-offending parent/caregiver
- ☐ the client will be informed of child protection notifications made unless safety concerns indicate otherwise
- ☐ child protection activities are documented in client files.

Best Practice

There is evidence to show that:

- ☐ practitioners take an advocacy and/or case management approach when working with clients and other agencies, police or legal services to address child protection concerns
- ☐ where the organisation is unable to take on the case management role, steps will be taken to identify an appropriate agency to take on this function in its stead.

8.2.2 Children and Young People

Minimum Practice

There is evidence to show that:

- ☐ a developmentally appropriate method of communicating child protection concerns and mandatory reporting requirements to young clients is taken
- ☐ the practitioner continually aims to identify and establish connection with a trusted and supporting adult known to the client
- ☐ the client is informed of any child protection notifications made, if it is considered safe to do so
- ☐ procedures are in place to ensure that services including case management are coordinated.

Best Practice

There is evidence to show that:

- ☐ procedures are subject to external review.

8.2.3 Adult Clients with Special Needs

Minimum Practice

There is evidence to show that:

- ☐ a developmentally appropriate method of communicating child protection concerns and mandatory reporting requirements to vulnerable adult clients is utilised
- ☐ if assessed as being required, the practitioner continually aims to identify and establish connection with another trusted and supporting adult known to the client
- ☐ the client is informed of any child protection notifications made, if it is considered safe to do so
- ☐ procedures are in place to ensure that services including case management are coordinated.

Best Practice

There is evidence to show that:

- ☐ procedures are subject to external review

Section 9: Client Records

Client records are any pieces of information pertaining to clients that anyone in the organisation collects, uses, stores or reports on. Data collection points may include, but are not limited to:

- *Service enquiry*
- *Initial contact / Intake*
- *Client Files (face to face/counselling and online)*
- *Group / activity booking or registration points*
- *Service evaluation points*
- *Feedback and complaint avenues*

Accurate and comprehensive record keeping enables organisations to appropriately plan and evaluate programs; be accountable to funding bodies, clients, and the community; fulfil any legal and ethical obligations; plan, implement and review therapeutic work with clients; coordinate interagency collaboration; and compete for funding and resources. Quality, systematic, integrated and accurate record keeping throughout the organisation, by all relevant employees is a necessity for all professional organisations.

Client records may be in a range of forms, including:

- *Telephone messages from clients*
- *Appointment / billing / receipt details*
- *Emails from/to clients*
- *Computer based client information (e.g. names, file/case numbers, demographic information)*
- *Funding body / agency data collection tools*
- *Client files*
- *Audio recordings*
- *Any film, photo or camera footage of any clients*
- *Reports to authorities or other services/agencies*
- *Advocacy letters / reports*
- *Intake forms*
- *Referral forms*
- *Other external reports or documents*

The collection of any records relating to clients must be consistent with the National Privacy Act 1988, in particular the Privacy Principles, as well as any state/territory health records legislation or regulations. See also ***Section 6: Consent*** *and* ***Section 7: Confidentiality****.*

Organisations recognise that information contained in client records may be useful for client advocacy and in supporting clients in any legal matter, including criminal proceedings. Clients pursuing criminal proceedings may approach services for access / use of their file while the file is 'open' or several years after file 'closure'. Long term secure storage of client files, beyond the legal minimum, may prove beneficial if past clients wish to access their file long after closure.

To ensure legibility all client intake forms and file notes should be recorded electronically. Organisational systems should ensure such records are recorded and stored securely. Where records are electronically stored organisations should have security and backup systems to avoid file loss or unauthorised access.

Organisations should also be aware of communication privilege laws in their state or territory. These laws define what information can and cannot be subpoenaed by a territory, state or Australian legal jurisdiction or their instrument and the protections those subpoenaed may have.

9.1 Organisational Systems

The organisation ensures that all data collection systems and content abides by the National Privacy Act (1988) and any relevant state/territory health records legislation.

Minimum Practice

There is evidence to show that the organisation:

- ☐ 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 National Privacy Principles and any relevant state/territory health records legislation and within the requirements of any professional association staff may be members of
- ☐ policies identify exclusions to confidentiality and state that, if safe to do so, it will inform the client when any of their information has been shared with another agency
- ☐ can demonstrate that any service reports, data collation, statistical analysis, and all relevant documents are de-identified prior to publication / use.

9.2 Client Files

The organisation recognises that information retained on client files can contribute to therapeutic planning and evaluation, and ultimately, better client outcomes.

Systems are in place to ensure confidentiality of client files. Although, information in a client's file may be required to be disclosed in certain circumstances, such as being subpoenaed for legal purposes.

Client files include any information / records relevant to intake, wait list management, counselling or other forms of service delivery.

Client files are the property of the organisation, not the practitioner or the client.

9.2.1 Quality Assurance and Accountability

Minimum Practice

There is evidence to show that:

- ☐ the organisation has policies and procedures in place regarding the establishment, maintenance, audit, and storage of client files

- ☐ clients are informed of any potential consequences of withholding consent to record data, such as the role of counselling notes in therapeutic planning and evaluation, or in seeking legal recourse
- ☐ additions to client files, including counselling notes, are made in a timely manner to reduce the risk of data/information loss or security breaches, and to ensure accuracy
- ☐ procedures are in place to manage file handover and the opening of subsequent files or new file parts.

9.2.2 File Security

Minimum Practice

There is evidence to show that:

- ☐ adequate procedures are in place to ensure confidentiality and security of all client files (paper based and electronic)
- ☐ there are procedures in place to ensure security of the file if / when being transported
- ☐ any copies or duplications of records are treated with equal security as the original
- ☐ closed files are archived securely and kept at least for the minimum period required to satisfy government stipulation.

9.2.3 File Inclusions

Best Practice

There is evidence to show that:

- ☐ the organisation can report on quantity and type of services delivered to clients
- ☐ sufficient client demographic and cultural information is collected for use in organisational reporting and future service planning
- ☐ child protection obligations are met
- ☐ intake and assessment information is treated as part of the client file
- ☐ the organisation's confidentiality and informed consent procedures have been complied with
- ☐ The organisation's counselling notes procedures enable:
    - meeting the minimum standards of any relevant professional association of the service's practitioners
    - the recording of client goals and therapeutic processes
    - tracking client therapeutic progress against client goals

- the storage / inclusion of any relevant attachments such as medical / legal reports, test results, letters, client generated material relevant to the therapy, referral information
- periodic case/client review and therapeutic evaluation
- the collection of any other details / data forms required by the organisation for accountability, statistical purposes, quality assurance,
- the records of any authorised information sharing or breaches of confidentiality.

9.2.4 File Access

Minimum Practice

There is evidence to show that the organisation:

☐ has policies and procedures to guide a response to a subpoena that is consistent with the communication privileges laws in their state / territory and which may include how to object / comply / develop substitute statement and guidelines for informing the client

☐ has systems in place to facilitate client access to their own file upon request, and that these procedures are mindful of client safety and wellbeing

☐ has procedures in place to ensure the security of the file when being accessed by the client.

Section 10: Staff Support

Vicarious Trauma

Vicarious trauma is held to be the most significant work health safety issue of the organisation. Vicarious trauma is "the inner transformation that occurs in the inner experience of the therapist [or other professional] that comes about as a result of empathic engagement with clients' trauma material" (Pearlman and Saakvitne 1995 p 31 in Morrison Z, 2012, p. 2).

The extent and degree of vicarious trauma is a function of the level and duration of exposure to trauma work. All workers, administrative staff and experienced practitioners, are at risk of vicarious trauma which can produce symptoms consistent with post-traumatic stress disorder as well as cognitive changes pertaining to self, others and the world. Vicarious trauma can be harmful to the practitioner and hamper work with clients, and the functioning of the organisation.

Being a workplace WHS matter, the responsibility for management of vicarious trauma is held jointly between employers and staff members. The employer is responsible for worker education and care and the staff member has a responsibility for monitoring symptoms and participating in in their tailored self care plan.

Vicarious trauma can impact on several fronts :

- *therapeutic work with clients: expressed through countertransference, feeling overwhelmed and helpless, numbing, therapeutic impasse, reluctance of delving deeper and progressing the client through their journey*
- *organisational / workplace: expressed through professional / role boundary violations, conflict, changes in productivity (over or under), hyper-sensitivity, high turnover, high sick-leave, lack of trust*
- *at the personal level: expressed through changes in relationships with family, friends, social connections, participation in interests / hobbies and civic activities, diminished well-being generally, and mental health specifically.*

As vicarious trauma occurs in the workplace, it is the workplace that provides the most appropriate platform for addressing vicarious trauma, through its culture, structure, systems and role design. Like any other work health and safety matter, management will take leadership in managing the issue in the workplace.

The flow on effects of vicarious trauma can also be experienced by those who have indirect contact with traumatic events, such as family and friends of the frontline trauma workers (Burke, J 2012, p 5-6).

Organisational Culture

The culture of the organisation can have a material impact on its employees. Culture is like the personality of the organisation and refers to shared beliefs, assumptions and expectations and is reflected in behaviours, norms, roles and values. A supportive culture in sexual assault services will recognise and try to normalise the stresses, strains and impacts of the work and be demonstrated by its activities, management style and expectations, policies, procedures, and the way people are treated and shown to be valued. Culture goes beyond words to include the way it feels to work there.

While organisational culture is largely set by organisation leaders it is also highly influenced by all staff members.

Unresolved or frequent workplace conflict and an unsupportive culture adds significantly to stress levels of all workers and may heighten the experience of trauma.

Work Health Safety

The organisation needs to have strategies in place to reduce the risk of vicarious trauma, respond with care to mitigate symptoms and manage vicarious trauma.

Management of vicarious trauma calls for a shared responsibility between management and workers. Management must acknowledge that vicarious trauma is a workplace hazard; that is a consequence of dealing with trauma and not due to a weakness or failing in the practitioner. Management must commit attention and resources to managing vicarious trauma and foster a supportive culture. Workers need to monitor their own vicarious trauma levels, be willing to share/debrief with colleagues, follow WHS policies and participate in self care strategies that they know work for them. It has been suggested that strong organisational support is linked to increased self care activities outside the workplace (Morrision Z, 2012, p. 7).

Qualifications, training and experience are also thought to contribute to the practitioner's sense of effectiveness and may reduce feelings of helplessness (Bober, T and Regehr, C, 2005, p 1). Experience in the field, in a supportive workplace environment, will also develop practitioner's skills in how best to care for themselves. Commitment of resources to creating a supportive environment, and to ongoing professional development of practitioners are both critical elements to managing vicarious trauma.

Professional Development

NASASV recognises that delivery of sexual assault services is a specialist trauma field that calls for high levels of education, training and experience. Each client group (for example: children, refugees, adult survivors,) calls for more specialised knowledge and experience, as does working within a broader context such as family law system, criminal justice system. All practitioners require ongoing professional development program; and particularly so when working with new issues or client groups.

All employees will benefit from their organisation having an integrated professional development framework. Such a framework may include, for example:

- *a comprehensive orientation program for all new staff*
- *basic/introductory training in the sexual assault services field for staff that do not have direct client contact*
- *mapping of skills and knowledge required to meet the needs of clients, including emerging communities/client groups*
- *skills and experience audit of existing staff – to identify strengths and gaps, or areas for further development*
- *a professional development program for each employee and tailored to the abilities and aspirations of the individual which may include, for example,*

appropriate client allocation, mentoring, reading program; networking opportunities; group supervision; attendance at conferences / seminars.

Clinical Supervision and Support

Clinical supervision is 'an intervention provided by a more senior member of a profession to a more junior member … of the same profession. This relationship is evaluative, extends over time' (Bernard, J and Goodyear, R, 1992, p 6).

Clinical supervision has three key purposes: (1) to assist the practitioner in their therapeutic work, and to provide an avenue for quality assurance and clinical accountability; (2) supporting and restoring the practitioner's personal-professional wellbeing; and (3) guiding professional development (O'Donovan, A, Halford, W, Walters, B, 2011, p 101). Through these functions clinical supervision may help with vicarious trauma management by detecting, monitoring and identifying strategies to assist the practitioner to manage the effects of the work and develop new skills and enhance sense of competency.

Clinical supervision is a function of the organisation intended to be used for practitioner-work related issues. It is not the venue for personal counselling for non work related issues, although it is recognised that life events may, from time to time, impact on a person at work and clinical supervision can help identify and manage this:

- *impacts derived from personal issue can be managed through personal counselling (for example, Employee Assistance Program)*
- *impacts arising out of challenging client work, or demands on skills should be a flag for professional development and review of client allocation protocols*
- *impacts resulting from interacting with trauma material is a vicarious trauma issue.*

Access to ad-hoc de-briefing, de-fusing and peer support are effective ways of assisting practitioners manage the impacts of clinical work, as a stop gap between clinical supervision sessions. Quality de-briefing follows a process to assist the practitioner to reflect on and 'unpack' their experience, their responses to it, and learning from it. Depending on the complexity of the issue, this can take some time, equivalent to a standard counselling session. A shorter de-fusing can be a stop-gap strategy while waiting for the opportunity to de-brief.

Celebrate the Good Things

NASASV acknowledges and promotes the positive side of working in the sexual assault services industry. Despite the heartache, many workers experience personal development, satisfaction and pride in their work. Good feelings can arise from being in a supportive team, witnessing positive outcomes in clients, engaging in meaningful activity underpinned by solid philosophy and embedded in a broad political context. These elements should be celebrated by organisations and nurtured for all workers.

Signpost for Future Work

NASASV recognises the need for the development of accredited post-graduate training opportunities in the field of vicarious trauma management resulting from sexual assault.

10.1 Organisation Commitment

A suitably qualified and well supported team is fundamental to an engaged workforce, quality work, and a workplace where people want to come to work, and better outcomes for clients.

Organisations recognise the specialist nature of sexual assault service and recruit appropriately qualified personnel.

Minimum Practice

There is evidence to show that the organisation:

- ☐ acknowledges the inherent traumatic nature of the work and puts a number of strategies in place to support all employees and build a positive, sharing, learning culture
- ☐ has a comprehensive framework with multi-pronged strategies for the monitoring and management of vicarious trauma
- ☐ ensures the physical environment is comfortable and well resourced with staff amenities
- ☐ has comprehensive and consistent policies and practices to address workplace conflict, staff disputes, grievances and complaints
- ☐ has policies and practices to assist all employees maintain work-life balance.

Best Practice

There is evidence to show that the organisation:

- ☐ provides access to an employees' assistance program.

10.1.1 Practitioner Qualifications

Minimum Practice

- ☐ There is evidence to show that:
- ☐ all clinical practitioners (counsellors, case workers, therapists) have: tertiary qualifications in counselling/social work/psychology or equivalent, at least 3 years counselling experience, and eligibility for membership to the relevant professional association
- ☐ administrative staff members receive orientation in sexual assault and sexual assault services, vicarious trauma, cultural competencies, containment and internal referral.

10.2 Professional Development

Access to ongoing professional development is required to assist all workers maintain competency and confidence in their role.

The organisation recognises that a diverse client mix / case load demands a broad range of knowledge skills and experience.

Minimum Practice

There is evidence to show that:

- ☐ the organisation can demonstrate an equitable approach to professional development for all employees
- ☐ staff members have a professional development plan outlining goals and strategies relevant to career aspirations and skill needs and which is reviewed annually
- ☐ the organisation has methods to document and track participation in professional development activities for all practitioners
- ☐ professional development needs identified through clinical supervision inform individual's professional development plan.

Best Practice

There is evidence to show that:

- ☐ the organisation has a comprehensive and integrated professional development framework to meet the needs of the organisation and individual employees.

10.3 Supervision

The organisation has a range of clinical support measures in place to assist practitioners manage the immediate, daily and ongoing impacts of trauma work and to maintain and improve on clinical practices. These would include, but not be limited to clinical supervision, de-briefing, de-fusing, peer support. Practitioners should have access to at least de-fusing at any time they need it.

10.3.1 Clinical Supervision

Minimum Practice

There is evidence to show that:

- ☐ all therapeutic practitioners have access to regular clinical supervision, funded by the organisation and attended in paid work time
- ☐ the frequency and duration of clinical supervision is matched to the practitioner's needs (level of experience / training; their case-load, appointment load, job related stress levels)
- ☐ clinical supervision is provided by appropriately qualified practitioner/s with additional training in clinical supervision
- ☐ clinical supervision is subject to review and evaluation
- ☐ there is a quality assurance feedback link between the clinical supervisor and management as function of work health safety, clinical accountability, and professional development planning

- ☐ supervision incorporates case file review, review of evaluation methods and client outcomes.

10.3.2 Debriefing De-fusing & Peer/Group Support

Ready access to debriefing, de-fusing and peer support are reflective of a supportive workplace.

Peer / group support may be formal or informal and include a variety of activities such as case presentations, topic discussions, group de-briefs, reading reviews, training, social activities.

Minimum Practice

There is evidence to show that:

- ☐ all workers have access to de-fusing when they need it this may include worker access to 24/7 counsellor support
- ☐ all workers have access /to individual debriefing on an ad-hoc or impromptu basis
- ☐ all practitioners participate in group support on a regular basis, in addition to their individual clinical supervision.

10.3.3 Line Management

The organisation recognises that line management deals with broader operational functions within the organisation. Line management is separate from clinical supervision, although linked through quality assurance, clinical accountability and professional development framework.

Minimum Practice

There is evidence to show that:

- ☐ all practitioners receive regular line management support
- ☐ there is a quality assurance connection between clinical supervision and line management.

10.4 Case Load Management

Every effort will be made to incorporate diversity into work tasks.

Minimum Practice

There is evidence to show that:

- ☐ sufficient time is allocated between counselling appointments to allow case note write up and de-fusing/de-briefing activities
- ☐ the organisation has policies and procedures in place to manage client allocation, case load, appointment load, and client mix in accordance with practitioner qualification, experience and clinical progress

- ☐ efforts are made to appropriately match client with practitioner experience, qualification and skills.

Best Practice

There is evidence to show that:

- ☐ a service demand management framework is in place to balance and coordinate intake, waitlists, client load, client review and client exit.

10.5 Staff Safety

The organisation has a comprehensive work health safety framework in place to minimise risks to health, wellbeing and safety and to manage incidences promptly.

Minimum Practice

There is evidence to show that:

- ☐ the organisation's work health and safety policies and practices are compliant with the relevant legislation
- ☐ the organisation policies and procedures in place to support staff to effectively manage potentially volatile or aggressive clients.
- ☐ there are adequate security systems in the building to protect the safety of clients and staff members
- ☐ policies and procedures are in place to manage, where relevant, the risks associated with night shifts, shift work, fatigue management, lone workers and distance driving for work.

Appendix: Services participating in consultation meetings:

Input and feedback was received from over 70 experts across Australia from 39 different services

Victoria

Loddon Campaspe Centre Against Sexual Assault

Gippsland Centre Against Sexual Assault

Eastern Centre Against Sexual Assault

Mallee Sexual Assault and Domestic Violence Services

Ballarat Centre Against Sexual Assault

Sexual Assault Crisis Line

CASA House

West Centre Against Sexual Assault

Northern Centre Against Sexual Assault

South Western Centre Against Sexual Assault

Upper Murray Centre Against Sexual Assault

Barwon Centre Against Sexual Assault

South East Centre Against Sexual Assault

Tasmania

Sexual Assault Support Services, Hobart

Department of Health and Human Services, Hobart

Laurel House, North Sexual Assault Group

New South Wales

NSW Ministry of Health

Grevillea Cottage Sexual Assault Service, Westmead Hospital

Liverpool, Fairfield, Bankstown Sexual Assault Service

Royal Prince Alfred Hospital Sexual Assault Service

Australian Capital Territory

Domestic Violence Crisis Service

Victim Support ACT

Canberra Rape Crisis Centre

The Service Assisting Male Survivors of Sexual Assault

South Australia

Uniting Communities, Adelaide

Yarrow place, Rape and Sexual Assault Service

Commission for Victims Rights

Western Australia

Perth Sexual Assault Resource Centre

Parkerville Childcare Youth Care

East Goldfields Sexual Assault Resource Centre, Kalgoorlie

Bunbury, Wararal Support Services

Queensland

Brisbane Rape and Incest Survivors Support Centre

ZigZag Young Women's Resource Centre

Gladstone Women's Health Centre

Centre Against Sexual Violence, Logan

The Women's Centre

Northern Territory

Strong Aboriginal Families Together, Darwin

Office of Children & Families.

Sexual Assault Resource Centre, Tennant Creek

Ruby Gaea, Darwin Centre Against Rape

Sexual Assault Resource Centre, Katherine

Sexual Assault Resource Centre, Darwin

Input was received from others who were not able to be present at the consultation meetings.

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