

## Responding to Sexual Assault (adult and child) Policy and Procedures

**Summary** Provides policy and practice guidance to NSW Health services in responding to children, young people and adults who have, or may have, been sexually assaulted and their families, carers and significant others. Details the functions and governance of NSW Health Sexual Assault Services including relating to crisis response, medical and forensic assessment and management and ongoing interventions and support. Clarifies the roles of other NSW Health services in responding to sexual assault.

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**Audience** Sexual Assault Services (SAS);NSW Health Violence, Abuse and Neglect (VAN) Services Management and Clinical Workforce;Emergency Department;All Mental Health Staff;Justice Health;Chief Executives of LHDs;All Employees of the NSW Ministry of Health;Clinical Staff -Emergency Departments and Clinical settings that provide Domestic Violence Services

## RESPONDING TO SEXUAL ASSAULT (ADULT AND CHILD) POLICY AND PROCEDURES

### PURPOSE

This Policy Directive provides policy and practice guidance to NSW Health services in responding to children, young people and adults who have, or may have, been sexually assaulted and their families, carers and significant others. It details the functions and governance of NSW Health Sexual Assault Services and clarifies the responsibilities of other NSW Health services in responding to sexual assault.

### SUMMARY OF MANDATORY REQUIREMENTS

This Policy requires that Local Health Districts (districts) and Speciality Health Networks (networks):

- Prioritise the health, safety and wellbeing of people who have experienced sexual assault (adult and child).
- Provide an integrated response to sexual assault within a public health approach.
- Adhere to the identified principles of intervention for responding to sexual assault.
- Comply with key reporting requirements related to sexual assault.
- Follow identified procedures and protocols for responding to sexual assault in Emergency Departments.
- Deliver services in ways that increase health, safety and wellbeing and minimise harm. This includes services seeking to prevent re-traumatisation and to ameliorate the impact of sexual assault on the person who has experienced it and their families/significant others.
- Deliver services in a way that is culturally safe and responds sensitively to people's needs, including the experiences of identified population groups with specific vulnerabilities and additional barriers to accessing services.
- Collaborate with interagency partners at local and district levels in responding to sexual assault.
- Ensure every district has at a minimum one Level 4 (or Level 6) Sexual Assault Service (SAS) within their geographic boundaries which provides 24 hour integrated psychosocial, medical and forensic crisis responses for both adults and children as well as the full range of other identified elements of the SAS service model.<sup>1</sup> For a SAS to qualify as a Level 4 as per the NSW Health [Guide to the Role Delineation of Clinical Services](#) it will meet the identified minimum requirements.

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<sup>1</sup> An exemption for existing service delivery arrangements that do not meet this requirement may be granted by the Secretary, Ministry of Health in writing.

- Apply the clinical processes, practices and management requirements for SASs set out in the *Responding to Sexual Assault (adult and child) Policy and Procedures*, including information sharing and records requirements.
- Comply with the NSW Health [Violence, Abuse and Neglect \(VAN\) Service Standards](#).

## IMPLEMENTATION

Chief Executives are responsible and accountable for:

- establishing mechanisms to ensure the directives and requirements of the *Responding to Sexual Assault (adult and child) Policy and Procedures* are applied, achieved and sustained;
- ensuring NSW Health staff understand and are aware of their obligations in relation to the *Responding to Sexual Assault (adult and child) Policy and Procedures* and related policies and procedures;
- ensuring resources are available to deliver and meet the directives and requirements of the *Responding to Sexual Assault (adult and child) Policy and Procedures*;
- ensuring that NSW Health staff are trained to operationalise and implement the *Responding to Sexual Assault (adult and child) Policy and Procedures*;
- communicating with the Ministry of Health through the Prevention and Response to Violence, Abuse and Neglect (PARVAN) Unit on reporting, communications and performance in relation to the *Responding to Sexual Assault (adult and child) Policy and Procedures*; and
- ensuring NSW Health staff are advised that compliance with the *Responding to Sexual Assault (adult and child) Policy and Procedures* is part of their patient / client care responsibilities.

Managers of NSW Health SAS and other NSW Health services specified in the *Responding to Sexual Assault (adult and child) Policy and Procedures* are responsible for:

- ensuring the requirements of the *Responding to Sexual Assault (adult and child) Policy and Procedures* are disseminated and implemented in their service; and
- monitoring implementation and compliance with the *Responding to Sexual Assault (adult and child) Policy and Procedures*.

NSW Health workers are responsible for:

- implementing and complying with the directives and requirements of the *Responding to Sexual Assault (adult and child) Policy and Procedures*.

## REVISION HISTORY

Version	Approved by	Amendment notes
February-2020 (PD2020_006)	Deputy Secretary Health System Strategy and Planning	Revises and will replace PD2005_614 and PD2005_607. Expands PD2005_607 to cover Sexual Assault Service responses to child sexual assault, provide the enabling policy environment to support stronger integration of Violence, Abuse and Neglect (VAN) services, and support the integration of VAN into other NSW Health services.
August-2005 (PD2005_614)	Deputy Director General, Primary Health and Community Partnerships Branch	New policy
July-2005 (PD2005_607)	Deputy Director General, Primary Health and Community Partnerships Branch	Amended and replaced 1999 policy.

## ATTACHMENTS

1. *Responding to Sexual Assault (Adult and Child) Policy and Procedures*

**Responding to Sexual Assault (Adult and Child)  
Policy and Procedures**



**Issue date:** February-2020

PD2020\_006

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## ABBREVIATIONS

Abbreviation	Term
District	Local Health District
CAMHS	Child and Adolescent Mental Health Services
<i>Care Act</i>	Children and Young Persons (Care and Protection) Act 1998
CASACAL	Child Abuse and Sexual Assault Clinical Advice Line
CASACS	Child and Adolescent Sexual Assault Counselling Services
CPCS	Child Protection Counselling Service
CPT	Child Protection Team
CPU	Child Protection Unit
CRT	Crisis Response Team (Community Services after hours on call).
CSA	Child Sexual Assault (0-16 years)
CSC	Community Services Centre — local Community Services office
CSNSW	Corrective Services NSW
CWUs	Child Wellbeing Units
DCJ	Department of Communities and Justice
DFSA	Drug-facilitated sexual assault
ECAV	Education Centre Against Violence
ED	Emergency department
EEK	Early Evidence Kit
EMDR	Eye Movement Desensitisation and Reprocessing
FASS	Forensic and Analytical Science Service
HETI	Health Education and Training Institute
HC	JCPRP Health Clinician
JCPRP	Joint Child Protection Response Program
JJNSW	Juvenile Justice NSW
JRU	Joint Referral Unit (part of the JCPRP)
MFER	Medical and Forensic Examination Record
Network	Specialty Health Network
ODPP	Office of the Director of Public Prosecutions
OOHC	Out-of-home care
Police	NSW Police Force
PHSB	Problematic or harmful sexual behaviour
ROSH	Risk of significant harm
SAIK	Sexual Assault Investigation Kit
SARO	Sexual assault reporting option
SAFABS	Sexual Assault Service
SCHN	Sydney Children's Hospitals Networks
SCAN Protocol	The Suspected Child Abuse and Neglect (SCAN) Medical Protocol
SHC	JCPRP Senior Health Clinician
VAN Service/s	Violence, abuse and neglect service/s
WAS	Witness Assistant Service

## GLOSSARY

Term	Description
Aboriginal English	Many Aboriginal people speak a form of Australian Aboriginal English some of the time, and it is the first (and only) language of a large number of Aboriginal children (Butcher, 2008).
Advocacy	Advocacy is based on the premise of empowerment and responding to the expressed needs and wishes of the client and aims to enable individuals to exert a greater influence or control over their lives. This may include providing correct and accessible information, enabling informed choices, outlining clear expectations, offering support, and assisting to negotiate the complex web of interagency services.
CASACAL (Child Abuse and Sexual Assault Advice Line)	NSW Health's CASACAL provides expert advice and support to doctors and nurses providing medical and forensic examinations and medical care to children and young people (up to their 16th birthday) who are suspected victims of sexual assault, physical abuse or neglect. Advice is provided for both urgent and non-urgent inquiries. CASACAL is staffed by specialist child protection paediatric consultants employed in NSW Health Child Protection Units. CASACAL should be called after local advice and escalation pathways have been followed. For further information, please see: <a href="https://www.aci.health.nsw.gov.au/_data/assets/pdf_file/0005/563864/CASACAL-Fact-Sheet.pdf">https://www.aci.health.nsw.gov.au/_data/assets/pdf_file/0005/563864/CASACAL-Fact-Sheet.pdf</a> .
Casework	A collaborative process of assessment, communication, planning, facilitation, clinical intervention and advocacy, which aims to meet an individual's psychosocial and emotional needs and promote quality cost-effective outcomes. While case work involves a range of activities to support a client in having their needs met, it does not require the level of coordination and responsibility by an individual worker that case management requires (see below).
Case plan	A written document that identifies the goals, interventions, and anticipated outcomes for the client. Case planning is a process of planning strategies to address a child/young person's safety and care needs to promote a client's wellbeing.
Case management	Co-ordination of individual client care aiming to improve service access and provision. It aims to strengthen outcomes for people and families through integrated and co-ordinated service delivery between services and interagency partners to their clients.
Care coordination	Also known as client advocacy or casework, this refers to assisting the client group to navigate and access information and services to ensure their needs are appropriately met during their contact with the complex interagency system involved in their care.

Carer	A range of people who play a role in supporting children and young people in families. Carers can be unpaid, as defined by the <i>NSW Carers Recognition Act 2010</i> , such as those caring for a child or young person with a disability or illness, or a child/young person providing care when other family members are not able to. Carers also include workers in paid roles providing care to children and young people.
Chapter 13A	Chapter 13A <i>Crimes (Domestic and Personal) Violence Act 2007</i> enables the exchange of information to facilitate access to domestic and family violence support services for people at serious threat. There is a protocol between agencies to support this process.
Chapter 16A	Chapter 16A of the <a href="#"><i>Children and Young Persons (Care and Protection) Act 1998</i></a> contains mechanisms for sharing information to another prescribed body that relates to the safety, welfare or wellbeing of a particular unborn child, child, young person or 'class of children' or young persons.
Child and young person	In accordance with the <a href="#"><i>Children and Young Persons (Care and Protection) Act 1998</i></a> , a 'child' for the purpose of this Policy Directive is someone under 16 years old (0-15 years) and a 'young person' is someone who is 16 or 17 years old. Occasionally in this policy and procedures, particularly when quoting the literature, 'child' may refer to someone under the age of 18 years old. However, wherever specific policy advice or direction is given, the definition above applies.
Child Protection Counselling Services (CPCS)	These are located in each Local Health District and are trauma-specific services that respond to the violence, abuse and neglect of children. CPCS also work towards the recovery and ongoing safety and wellbeing of children involved with the care and protection system. CPCS provide services to children and young people up to the age of 18 years and their families/carers who have experienced, or are believed to have experienced: physical or emotional abuse; sexual abuse; neglect; and/or exposure to domestic and family violence. CPCS also work with children with PHSB where this is a secondary presenting issue, and with other violence, abuse and neglect issues where these impact on the care and safety of children and young people. CPCS aim to support children to achieve safety, security and permanency through family preservation, family restoration, or moving to a sustainable long-term placement.
Child Protection Units (CPUs) / Child Protection Team (CPT)	NSW Health has three specialist hospital-based Child Protection Units/Teams located within the Sydney Children's Hospitals Network at Westmead and at Randwick, and Hunter New England Local Health District. These provide tertiary child protection services for children and young people who have experienced physical, sexual, and emotional abuse; domestic and family violence; and neglect. They provide comprehensive paediatric medical, forensic and psychosocial assessments and treatment. Each child protection service has access

	to medical imaging and pathology services, intensive care, surgery and other subspecialties. Child protection medical consultants are available for medical consultation and second opinions to staff across NSW.
Child Sexual Assault Medical Protocol	A written record used by medical and forensic examiners in NSW Health SAs to record in a standardised format forensic and relevant medical details concerning initial sexual assault examinations for children 0-14 years of age. This document may, where appropriate, be used for young people 14-17 years. Otherwise, an Adult Medical and Forensic Examination Record (MFER) may be used.
Child Wellbeing Unit (CWU)	The NSW Health CWU provides advice to NSW Health workers if they have concerns about the safety, welfare or wellbeing of a child, young person or unborn child. The CWU can: <ul style="list-style-type: none"> <li>• provide advice and information to clearly identify child protection risks, harm and vulnerabilities</li> <li>• advise on interventions, treatments and/or referrals for vulnerable or at-risk children, young people and families</li> <li>• provide relevant information held about past child protection-related concerns</li> <li>• provide guidance about how to raise health, safety and wellbeing concerns with parents</li> <li>• where required, escalate suspected risk of significant harm matters to the Child Protection Helpline.</li> </ul>
Children with PHSB	This term refers in this document to children with problematic or harmful sexual behaviours (PHSB) under the age of criminal responsibility; which is currently 10 years old.
Client	A person receiving psychosocial care and interventions.
Client advocacy	The activities to help meet the specific needs of an individual client or family and, in particular, refers to assisting them to navigate service systems, including negotiation of the complex web of interagency services. It is based on the premise of empowerment and responding to the expressed needs and wishes of the client and aims to enable individuals to exert a greater influence or control over their lives.
Crisis	A time of intense difficulty or danger. This danger may be external to the client (e.g. acute risk from a perpetrator) or internal to the client (e.g. acute suicidality). For SAs, a crisis refers to the emotional, physiological, and psychological outcomes of a recent sexual assault (within the last seven days), new disclosure of a past sexual assault, or the experience of a significant life event (see <a href="#">Section 14</a> ).
Crisis intervention	An intervention that is clearly distinct from other forms of counselling. It is prompt; time limited — working to contain rather than to extend and to explore; focused on current issues; focused on safety — in relation to the perpetrator and in relation to client risk of harm to self or others; and the worker role is more active, sometimes even directive.



Cultural competence	The ability to identify and challenge one's own cultural assumptions, values and beliefs and to demonstrate respect and minimise adverse effects on communication with any client. Cultural competence includes empathy and appreciation that there are many different ways of viewing the world, influenced by culture.
Culture	The language, beliefs and practices different groups of people use to articulate their identity, often in relation to specific traditions of ethnicity, race, religion, spirituality, occupation, stage of life, social relations and sexual identity.
Education Centre Against Violence (ECAV)	ECAV is NSW Health's state-wide unit responsible for workforce development in the specialist areas of prevention and response to violence, abuse and neglect, including a specific focus on Aboriginal and culturally and linguistically diverse (CALD) communities. ECAV provides statewide face-to-face and online worker training, community awareness and development programs, agency and policy consultation, clinical supervision and resource development for NSW Health and other government and non-government organisations.
Early Evidence Kit (EEK)	A sterile kit containing water for a mouth rinse, a gauze wipe and instructions for evidence collection, to be provided when a medical forensic examination is unavoidably delayed. The EEK is packaged for forensic analysis and retained under chain of evidence procedures.
Forensic assessment	An assessment of a sexual assault patient by a medical and forensic examiner for the purpose of the collection of medical history and history of the assault, physical injury documentation, and biological forensic evidence collection to assist with a criminal investigation. In NSW, the forensic assessment and examination is offered alongside medical assessment, medical examination and care, and occurs as a parallel rather than a separate process. The term 'medical and forensic examination' is therefore most commonly used (see definition below).
Health service; Health facility	Any public health organisation defined under the <i>Health Services Act 1997</i> , the Ambulance Service of NSW, Health Infrastructure, HealthShare NSW, NSW Health Pathology, any other administrative unit of the Health Administration Corporation, and Albury-Wodonga Health in respect of staff who are employed in the NSW Health Service. This includes violence, abuse and neglect services, including SASs and integrated services.
Health worker/staff	Anyone working in NSW Health, whether as a paid staff member or engaged in any other capacity, including as a volunteer, visiting practitioner, student attending clinical placement, or anyone else appointed on an honorary or contractual basis.
Institutional abuse	The mistreatment or neglect of a child, young person or adult by a regime, or individuals within settings and services, which that child,

	young person or adult uses or lives within. Such abuse violates the person's dignity, resulting in a lack of respect for their human rights.
Joint Child Protection Response Program (JCPRP)	NSW Health is an equal partner in JCPRP, working jointly with NSW Police and DCJ. JCPRP, which was formerly Joint Investigation Response Teams (or JIRT). It provides a comprehensive and coordinated safety, criminal justice and health response to children and young people alleged to have suffered sexual abuse, serious physical abuse or extreme neglect. JCPRP undertakes joint investigations of statutory child protection matters that require a criminal justice response. Its model aims to deliver improved outcomes for vulnerable children and young people and their family members or carers.
Joint Referral Unit (JRU)	The JRU provides a centralised decision-making process for accepting and investigating JCPRP referrals. All JCPRP reports go through the Child Protection Helpline to the JRU. The JRU accepts referrals that require criminal investigation, such as cases of sexual assault and serious physical abuse and neglect. The JRU is staffed by JCPRP agency partners and the procedure of decision-making is conducted jointly by JRU Managers for NSW Police, NSW Health and DCJ.
Local Health Districts and Speciality Health Networks	NSW Health has a total of fifteen Local Health Districts: eight in metropolitan areas and seven in rural and regional NSW. In addition, there are three Specialty Health Networks (SHNs): the Sydney Children Hospitals Network; Justice Health and Forensic Mental Health Network; and St Vincent's Health Network Sydney.
Mandatory reporter	A person who as part of their work delivers health care, welfare, education, children's services, residential services or law enforcement to children or young people. Mandatory reporters are required under section 27 of the <a href="#">Children and Young Persons (Care and Protection) Act 1998</a> to make a report to the Secretary of Family and Community Services (via the <a href="#">Child Protection Helpline</a> ) if they suspect or have information that a child is at risk of significant harm as detailed under section 23 of the Act.
Medical examination	A general medical assessment and examination of children, young people and adults who have experienced sexual assault, offered for therapeutic purposes to assess the health and treatment needs of the patient, as well as provide reassurance about any fears the patient may have regarding injuries or other health concerns.
Medical and forensic consultation	A medical and forensic consultation is a broader term that covers the whole process of a medical and forensic intervention with a sexual assault patient, from consent through to taking a history, the medical and forensic examination, treatment and follow up.
Medical and forensic examiner	Specially trained NSW Health doctors and sexual assault nurse examiners (SANEs) who perform medical and forensic examinations



	(including medical assessment, medical examination, treatment and forensic evidence collection) for victims of sexual assault for SASs.
Medical and forensic examination	A combined general medical assessment and examination (see definition above) and a forensic assessment and examination (see definition above) provided to victims of sexual assault. In NSW Health, a general medical assessment and examination may be provided without a forensic assessment and examination. However, a forensic assessment and examination must be accompanied by a general medical assessment and examination. See also 'Non-urgent medical and forensic assessment following child sexual abuse' below.
Medical assessment and care	Includes the medical care offered by the medical and forensic examiner, with the back-up of an ED for all acute cases, and appropriate referrals and follow-up. This includes, for example, the medical history, assessment and care for injuries; providing advice in response to medical concerns or questions; pregnancy prevention where appropriate; STI prevention and treatment where appropriate; assessment of acute mental state, including suicidal ideation; and, where clinically appropriate, brief assessment for non-acute medical concerns including alcohol and drug use. Follow-up medical care must be arranged by the SAS or referral to another service as appropriate. See also 'Non-urgent medical and forensic assessment following child sexual abuse' below.
Medically cleared	Assessed by the triage nurse as fit to see the SAS team immediately or assessed by a treating ED physician (e.g. after treatment for serious injuries) as being medically fit to see the SAS team.
Medical and Forensic Examination Record (MFER)	The MFER is the written record of the examination of an adult victim of sexual assault detailing the history, physical examination and samples collected as part of the process. It is to be used as an adjunct to the Sexual Assault Investigation Kit (SAIK).
My Health Record	A secure online summary of an individual's health information. Healthcare providers authorised by their healthcare organisation can access My Health Record to view and add to their patients' health information. Information available through My Health Record can include a patient's health summary, medication prescribing and dispensing history, pathology reports, diagnostic imaging reports and discharge summaries.
New Street Services	A specialist, community-based, early intervention service to young people (10-17 years) across the state who have engaged in sexually harmful behaviours towards others. New Street uses a child protection framework that addresses the safety, welfare and wellbeing of: children and young people who have been sexually harmed; other children and young people surrounding the child or young person who has been

	sexually harmed; and the child or young person aged 10-17 years who has displayed harmful sexual behaviour.
Non-urgent medical and forensic assessment following child sexual abuse	The provision of medical care in a forensically informed process that includes obtaining all relevant medical history and forensic information; performing a comprehensive physical examination, including ano-genital examination where relevant; testing for pregnancy and STIs if indicated; and formulating a health management plan.
On-call SAS counsellors	SAS counsellors employed to provide psychosocial response to children, young people or adults presenting to a NSW Health facility having experienced a recent sexual assault or who are in crisis (see <a href="#">Section 14</a> ).
OOHC (out-of-home care)	OOHC is one of a range of services provided to children who are in need of care and protection (as well as to their families). This type of service assists and supports children and young people in a variety of care arrangements other than with their parents. These arrangements include foster care, placements with relatives or kin, and residential care. In most Australian jurisdictions, children will be placed in OOHC in conjunction with being placed on a care and protection order.
Parent / caregiver	An adult who attends to and has responsibility for the needs of a child or young person or a dependent adult as a guardian or 'person responsible', or holding parental responsibility under the <i>Children and Young Persons (Care &amp; Protection) Act 1998</i> .
Patient	Someone receiving medical care and treatment.
People who have experienced sexual assault	Unless otherwise specified (e.g. using specific terms such as children), this term refers to individuals of any age — that is children, young people and adults — who have experienced sexual assault.
Police faxback	A program where NSW Police provide formal referrals through email (or, historically, fax) to service agencies following a police call out for domestic and family violence.
Prescribed body	Chapter 16A of the <a href="#">Children and Young Persons (Care and Protection) Act 1998</a> provides a scheme for information-sharing among human services and justice agencies and NGOs 'prescribed bodies'. A ' <b>prescribed body</b> ' means: <ul style="list-style-type: none"> <li>the NSW Police Force, a public service agency or a public authority</li> <li>a government school or a registered non-government school within the meaning of the <i>Education Act 1990</i></li> <li>a TAFE establishment within the meaning of the <i>Technical and Further Education Commission Act 1990</i></li> </ul>

	<ul style="list-style-type: none"> <li>• a public health organisation within the meaning of the <i>Health Services Act 1997</i></li> <li>• a private health facility within the meaning of the <i>Private Health Facilities Act 2007</i></li> <li>• any other body or class of bodies (including an unincorporated body or bodies) prescribed by the <i>Care and Protection Act</i> for the purposes of this section, which includes: enrolled nurses and registered nurses; medical practitioners; midwives; psychologists; occupational therapists; and speech pathologists eligible for membership of Speech Pathology Australia.</li> </ul>
Problematic or harmful sexual behaviour (PHSB).	An umbrella term inclusive of the continuum of all concerning sexual behaviours that children may display. The term 'problematic sexual behaviour' has been broadly adopted to describe behaviour of a sexual nature outside the range accepted as 'normal' for a child's age and level of development, is detrimental to development and normal functioning and places the child at risk of harm. The term 'harmful sexual behaviour' is used to recognise that this behaviour may harm the child themselves, harm other children subjected to this behaviour, or place either child or children at risk of harm.
Psychosocial assessment	An evaluation of a client's mental, physical, social, physiological and emotional health. It takes into account all aspects of their life, including their perception of themselves and ability to function in the community.
Psychosocial services	A range of interventions aimed at addressing the client's mental, psychological, social and emotional needs. This may include, but is not limited to, individual and family/group counselling, group work, psychoeducation, casework and care coordination, court preparation and support, and the provision of support services to other professionals to meet these needs (e.g. professional consultation and training to other health professionals).
Recent sexual assault	A sexual assault that occurred within seven days of the victim's presentation to a NSW Health facility.
Recognition payment	Part of the victim support package and is intended to recognise the trauma suffered by a victim due to the act of violence. The appropriate category of recognition payment is determined by the nature of the offence/s committed against a victim and degree of injury caused. More information about recognition payments is at: <a href="https://www.victimsservices.justice.nsw.gov.au/Pages/vss/vs_financial_support/vs_recognitionpayment.aspx">https://www.victimsservices.justice.nsw.gov.au/Pages/vss/vs_financial_support/vs_recognitionpayment.aspx</a>
Risk of significant harm (ROSH)	Under section 23 of the <a href="#"><i>Children and Young Persons (Care and Protection) Act 1998</i></a> , 'risk of significant harm' refers to where current concerns exist for the safety, welfare or wellbeing of the child or young person because of the presence, to a significant extent, of a range of circumstances specified in the legislation. These include if the child or

	young person has been, or is at risk of being, physically or sexually abused or ill-treated.
Sexual abuse	‘Sexual activity or behaviour that is imposed, or is likely to be imposed, on a child or young person by another person. Sexual activity includes the following: sexual acts; exposure to sexually explicit material; inducing or coercing the child or young person to engage in, or assist any other person to engage in, sexually explicit conduct for any reason and exposing the child or young person to circumstances where there is risk that they may be sexually abused’ ( <a href="#">Child Wellbeing and Child Protection Policies and Procedures for NSW Health</a> , p. 38).
Sexual assault	When a person is forced, coerced or tricked into sexual acts against their will or without their consent, or if a child or young person is exposed to sexual activities. The definition of sexual assault may vary in different contexts, however for this document the following definition from section 61I of the <a href="#">Crimes Act 1900</a> is used: ‘Any person who has sexual intercourse with another person without the consent of the other person’. In addition to outlining various types of sexual assault offences, the Act also outlines other sexual offences related to sexual assault including: sexual touching; various sexual offences against children including children — sexual assault, children — sexual touching, children — sexual act, children — procurement and grooming; and a range of other sexual offences.
Sexual Assault Services (SASs)	NSW Health has a network of specialist SASs delivered by local health districts and speciality health networks. Every district has a SAS that operates 24 hours a day, seven days a week. SASs provide services to clients/patients and their families/significant others, professionals and communities. The key elements of the SAS model are: <ol style="list-style-type: none"> <li>1. crisis response</li> <li>2. medical and forensic service</li> <li>3. ongoing counselling and other therapeutic interventions</li> <li>4. systems advocacy</li> <li>5. court preparation and support</li> <li>6. professional consultation and training</li> <li>7. community engagement, education and prevention.</li> </ol>
SAS business hours	The normal business hours of SAS are Monday to Friday 8:30am-5pm.
SAS counsellors	SAS counsellors are employed by a NSW Health SAS to provide a range of psychosocial services, including: crisis and ongoing counselling and support, advocacy, court preparation, court reports, and court support, casework, community education and prevention, and professional consultation and training. SAS counsellors may be employed in the daytime or for after-hours service (or both).

SAS staff	All staff employed by NSW Health SAS including, but not limited to, managers, clinical leads, medical directors/medical leads, SAS counsellors, medical and forensic examiners, administrative staff, and intake workers.
Sibling sexual abuse	Sexual abuse between children (siblings), which may involve, but is not limited to: an age difference; the use of verbal, emotional and physical coercion; the dynamics of grooming or conditioning; threats and bribery/trickery; intimidation; or lack of consent, and includes a range of sexually abusive or harmful behaviours.
Significant life event	For the purpose of this policy and procedures a significant life event is defined as: the birth of a child, the death of a loved one, the death of the person who abused them, seeing the person who abused them, high-risk domestic or family violence, homelessness, suicidal ideation or attempt, or recent sobriety or relapse with drugs and alcohol.
Significant other	Someone who is an important person in someone's life but is not in a family relationship with them. This may include friends and carers.
Structured professional judgement approach	Typically, this is an approach to assessing risk and safety in the context of domestic and family violence (DFV). The following types of information are used and integrated to determine levels of risk: victim statements and narratives, particularly about the level of fear and self-assessment of risk; use of a well-tested actuarial risk assessment tool, which is appropriate to the expertise of workers expected to use the tool; professional judgement and practice wisdom drawn from workers' specialist knowledge of DFV to inform the process; and information gathered from other organisations, such as criminal records.
Systems advocacy	Seeking to influence and change systems as a whole. It 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' (National Association of Services Against Sexual Violence, 2015, p. 18). This may include through advocacy for legislation, policy or practice change to positively impact on people who have experienced violence, abuse and neglect generally.
Timely	Prompt, expedient and done at the time of the event or presentation so as to reduce the loss of evidence, where possible.
Trauma-informed service	'A program, organization, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization' (Substance Abuse and Mental Health Services Administration, 2014, p. 9).



Trauma-specific service	A trauma-specific service is one that is aware of the possibility of ongoing traumatisation or re-traumatisation of clients and of the direct and indirect impacts on its staff, and takes steps to reduce this wherever possible. A trauma-specific service recognises there are many potential pathways to recovery and to building resilience in clients. A trauma-specific service provides therapeutic approaches with the aim of helping a person manage and reduce trauma-related symptoms and integrate their experiences of trauma so these no longer intrude on the present (Bateman, Henderson & Kazelman, 2013; Falloot & Harris, 2006; Substance Abuse and Mental Health Services Administration, 2014).
<a href="#">Victims Services</a>	Provides support, information, referrals, counselling and compensation services to victims of violent crimes and witnesses to violent crimes. It also provides compensation and counselling services to relatives of someone who has died as a result of a violent crime. Victims Services is part of the Department of Attorney General and Justice.
Vicarious trauma	A 'transformation in a worker as a result of working with a person who has been traumatised. Vicarious trauma is a cumulative effect of working with trauma which can affect many aspects of a person's life. It may consist of short-term, or longer term effects that continue after the work has finished. Some effects of vicarious traumatisation parallel those experienced by the trauma survivor, and can lead to a person experiencing the symptoms of PTSD' ( Bateman, Henderson & Kazelman, 2013, p. 65).
Warm referral	Where a clinician refers to another service or service provider by directly contacting the services on the client's behalf and handing over to the other service provider. This is in contrast to a 'cold' referral where the clinician provides the referral to the client to follow up themselves.
WAS (Witness Assistance Services)	Witness Assistant Service is part of the ODPP. Its role is to assist and support both victims of crime and vulnerable prosecution witnesses. The main aims of the WAS are to minimise re-traumatisation that might result from participating in the criminal justice system and to enable witnesses to give their evidence in court to the best of their ability.
Wellbeing medical assessment	See 'Non-urgent medical and forensic assessment following child sexual abuse'.

## TERMINOLOGY

In this document, the term 'person who has experienced sexual assault' is usually used. Occasionally, 'victim' or 'survivor' is used for brevity, accuracy or to reflect cited references. The term 'client' is used to refer to service users and the term 'patient' when referring to medical and forensic responses.

Gender neutral terms such as ‘victim’, ‘survivor’ and ‘perpetrator’ are used in recognition that NSW Health services are available to anyone who has experienced sexual assault regardless of their gender, or the gender of the person who perpetrated the assault. It is however, important to recognise that sexual assault is a gendered crime where the majority of victims are female and the majority of perpetrators are male. There are also high rates of sexual violence against and particular vulnerabilities and barriers to accessing support for transgender, non-binary, gender diverse and intersex people.

The term perpetrator will usually be used to refer to an adult who has sexually assaulted another person. The term offender is not used, unless citing a specific source or for reasons of accuracy in the context, as this usually refers to someone has been charged with and/or convicted of a criminal sexual offence.

The term ‘children with problematic or harmful sexual behaviour (PHSB)’ is used in this document to refer to children under the age of criminal responsibility; which is currently 10 years old. The term ‘problematic sexual behaviour’ has been broadly adopted to describe behaviour of a sexual nature outside the range accepted as ‘normal’ for a child’s age and level of development, is detrimental to development and normal functioning, and places the child at risk of harm. The term ‘harmful sexual behaviour’ is used to recognise this behaviour may harm the child themselves, harm other children subjected to this behaviour, or place either child or children at risk of harm.

Children with PHSB are not referred to as ‘offenders’ or ‘perpetrators’. In addition to being incorrect in the case of ‘offender’ (an offender is a person charged with and/or convicted of a criminal sexual offence, which is not possible for children below the age of criminal responsibility, which is currently 10 years old), these are global descriptions which label the child with this behaviour, limit scope of assessment and practice, and may cause harm to the child and others connected to them (Chaffin, 2008).

The term ‘family/significant other’ is used to include:

- for children and young people: their parents and/or carers, siblings and other significant others from their extended family; people from out-of-home care (OOHC)<sup>1</sup> (if applicable); friends; or other people from their community.
- for adults: their partner; their parents; their children; carers (e.g. where they have a disability); extended family members; friends; or other people from their community.

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<sup>1</sup> Out-of-home care is one of a range of services provided to children who are in need of care and protection (and their families). This type of service assists and supports children and young people in a variety of care arrangements other than with their parents. These arrangements include foster care, placements with relatives or kin, and residential care. In most Australian jurisdictions, children will be placed in out-of-home care in conjunction with being placed on a care and protection order.

## **STATEMENT OF COMMITMENT TO ABORIGINAL FAMILIES AND COMMUNITIES**

Aboriginal people are the first peoples of Australia, and are part of the longest surviving culture in the world. With more Aboriginal people living in NSW than in any other Australian state or territory, improving the health and wellbeing of Aboriginal communities is a key focus for the NSW Government. It is the resilience of Aboriginal people that provides the very foundation upon which further efforts to improve Aboriginal health and wellbeing can be made (NSW Ministry of Health, 2012).

The consequences of colonisation as well as social determinants of health, such as education, employment, and housing, have had a devastating impact on the social, emotional, economic, and physical living conditions of Aboriginal people for more than 200 years. These factors continue to directly contribute to the health disparities experienced by many Aboriginal communities, and the significant over-representation of Aboriginal children and young people in the statutory child protection system. An appreciation of these factors is critically important to closing the health gap between Aboriginal and non-Aboriginal people.

NSW Health recognises that Aboriginal health encompasses not only the physical wellbeing of an individual, but also the social, emotional and cultural wellbeing of the whole community within which each individual is able to achieve their full potential as a human being (National Aboriginal Health Strategy Working Party, 1989). As such, there exists an appreciation that the health of each individual is inextricably linked to the health and wellbeing of the wider community.

Aboriginal children and young people, like non-Aboriginal children and young people, are vulnerable to the impact of trauma through direct exposure to an accident, family violence and abuse (Atkinson, 2013). In addition to this, it is important to acknowledge that the individual and collective experiences of trauma from historical events associated with the colonisation of Indigenous land and genocide can be profound. The passing of trauma legacies through generations to children is commonly known as intergenerational trauma.

Although the effects of childhood trauma can be severe and long lasting, recovery can be mediated by interventions that nurture the spirit, resilience and cultural identity of Aboriginal families and communities. Genuine appreciation and understanding of the impact of power dynamics, the importance of Aboriginal worldviews, and the limitations of Western approaches in the assessment and treatment of trauma is central to demonstrating respect for the lived experiences of Aboriginal people.

NSW Health is committed to improving the health and wellbeing of Aboriginal families and communities in NSW by supporting the ongoing efforts of Aboriginal people and their communities in reducing the impact of the social determinants of health, and the effects of individual and collective trauma legacies. NSW Health recognises the significance of family and community to identity, and is committed to Aboriginal families being connected and determining their own futures.



## PART ONE: UNDERSTANDING THE ISSUES

### 1 INTRODUCTION

#### 1 Introduction: summary

- NSW Health services will provide an integrated response within a public health approach to sexual assault (adult and child).
- All NSW Health workers have responsibilities for responding to sexual assault (e.g. reporting obligations, following principles of intervention). In addition, the following NSW Health services have specific roles and responsibilities in service responses to sexual assault: Sexual Assault Services (SASs), other violence, abuse and neglect (VAN) services, Emergency Departments (EDs), mental health services, Justice Health and Forensic Mental Health Network services.
- SASs will provide integrated psychosocial, medical and forensic services to adult and child victims of sexual assault (adult and child) and children with PHSB (whether or not that child has experienced sexual assault). SAS will also respond to sexual assault through professional consultation and support, systems advocacy, and prevention and community education.

#### 1.1 Purpose and background

This *Responding to Sexual Assault (Adult and child) Policy and Procedures* provides policy and practice guidance for NSW Health services in responding to children, young people and adults who have or may have been sexually assaulted, along with their families/significant others. While its focus is NSW Health SASs, it also provides the roles and responsibilities in responding to sexual assault of other NSW Health services and workers, including (but not limited to): EDs, the Joint Child Protection Response Program<sup>2</sup> (JCPRP), mental health services, Justice Health and Forensic Mental Health Services and Violence, Abuse and Neglect (VAN) services other than SASs. SASs are also the lead agency in NSW Health for children with problematic or harmful sexual behaviour (PHSB). As a result, some guidance is provided on SASs' responsibilities for this client group where these intersect with other SAS responsibilities. Detailed guidance is, however, provided in a separate policy on the Children's Sexual Behaviours Program.

This document is intended to support quality services and consistent practice across NSW Health through evidence-informed practice guidance on integrated service delivery responding to sexual assault. It replaces the following NSW Health policies:

- *Sexual Assault Services Policy and Procedures Manual (Adult)* PD2005\_607
- *Clinical Practices — Adult Sexual Assault Forensic Examinations Conducted by Nurse Examiners* PD2005\_614

<sup>2</sup> Formerly known as the JIRT (Joint Investigation Response Team).

- Child Sexual Assault Procedure Manual from the *NSW Health Child Protection Policy and Procedures Manual*.

This policy directive was developed in consultation with an expert reference group with representatives from: SASs and Integrated VAN Services (psychosocial and medical and forensic); Child Protection Units (CPUs); Education Centre Against Violence (ECAV); Centre for Aboriginal Health; JCPRP Joint Referral Unit (JRU) and senior health clinicians; and Prevention and Response to Violence, Abuse and Neglect (PARVAN) clinical advisors. They were also informed by literature and other best-practice guidance, including: the *Standards of Practice Manual For Services Against Sexual Violence* (NASASV, 2015); *Victorian Centres Against Sexual Assault Standards of Practice* (CASA Forum, 2014); *The Last Frontier' Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery* (Kezelman and Stavropoulos, 2012); *Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines* (World Health Organization [WHO], 2013a); and the Royal Commission into Institutional Responses to Child Sexual Abuse (Royal Commission, 2017).

## **1.2 Violence, abuse and neglect as a public health issue**

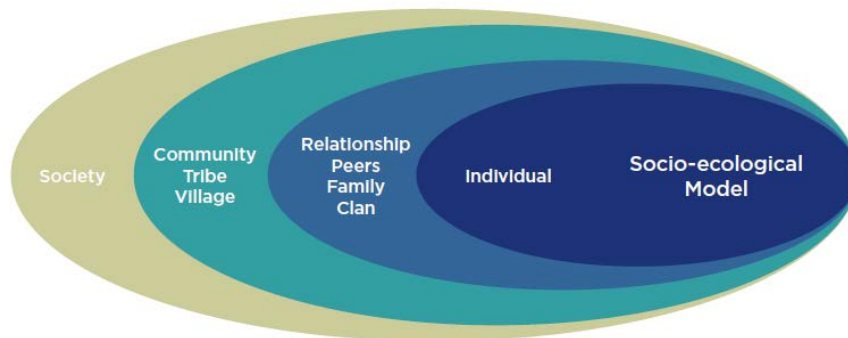
In 1996, the World Health Assembly declared violence a major public health issue and in 2002 released the first *World Report on Violence and Health*, stating:

The public health sector is directly concerned with violence not only because of its huge effect on health and health services, but also because of the significant contributions that can and should be made by public health workers in reducing its consequences. Public health can benefit efforts in this area with its focus on prevention, scientific approach, potential to coordinate multidisciplinary and multi-sectoral efforts, and role in assuring the availability of services for victims. (Krug, Mercy, Dahlberg, & Zwi, 2002, p. 1083)

The World Health Organization recognises that violence results in both immediate and long-term negative health consequences to the individual, their family and the community. They argue that the effects of violence are serious, continue long after the abuse has ended and, for many victims, are life-long. People who have experienced or been exposed to violence have a greater risk of developing a range of poorer health outcomes, report poorer physical health overall, are more likely to engage in practices that are harmful to their health, and experience difficulties accessing the appropriate health service (WHO, 2002). A summary of the evidence on the extensive health consequences of violence, abuse and neglect is available from the *Integrated Violence, Abuse and Neglect Statistics and Research Project* at <http://www.ecav.health.nsw.gov.au/van-statistics-and-research/>.

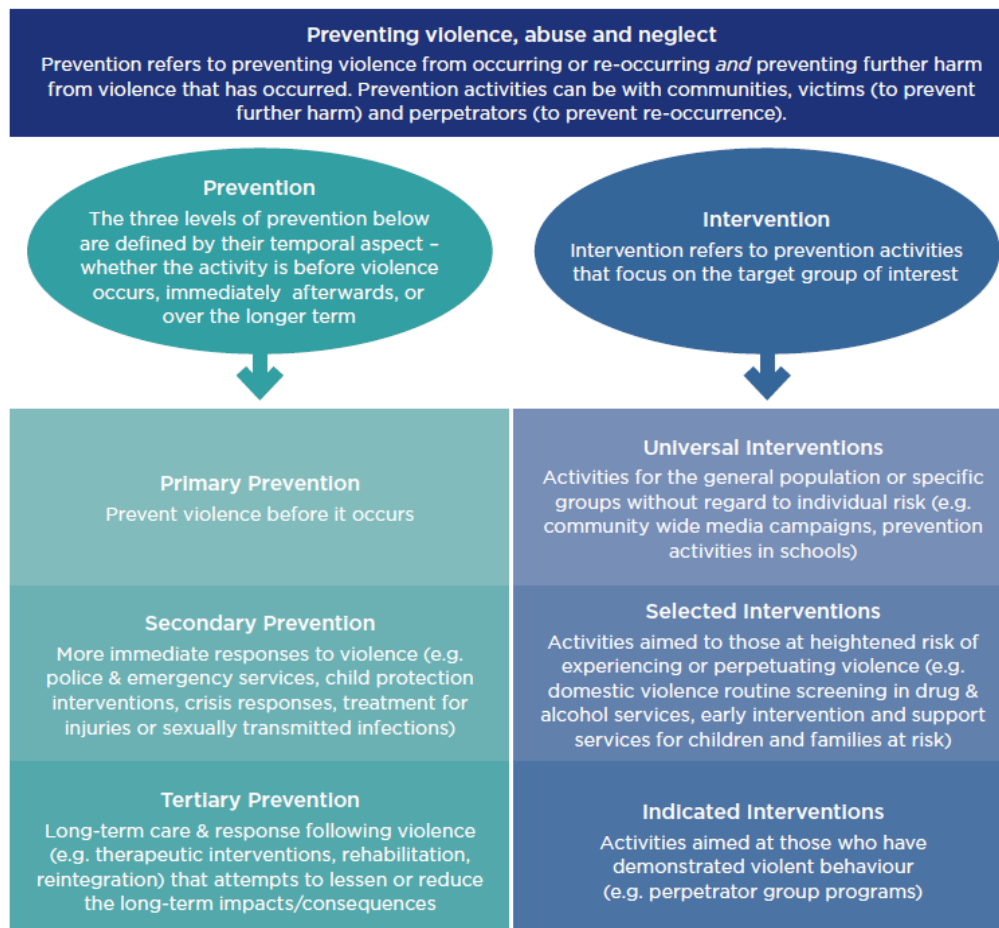
The World Health Organization promotes a public health approach to violence, abuse and neglect built on the socio-ecological model, where violence is understood as “the result of the complex interplay of individual, relationship, social, cultural and environmental factors” (WHO, 2002, p. 12), as illustrated in Figure 1.

**Figure 1: Socio-ecological model for understanding violence**  
(adapted from WHO, 2002, 2004, by ECAV)



This public health approach argues violence is preventable and its impact can be reduced similarly to other public health concerns (e.g. infectious diseases). It includes: being evidence-based; emphasising collective action, collaboration and integration across many sectors and disciplines; and focusing on prevention, both in preventing violence occurring or re-occurring and preventing further harm from violence that has already occurred (WHO, 2002, 2004). The public health model conceptualises prevention as illustrated in Figure 2 below (developed from WHO, 2002, p. 15).

**Figure 2: Public health approach to prevention**



The World Health Organization (WHO) also specifically recognises sexual violence, including sexual assault, as a serious public health and human rights issue with long-term personal, social, health and economic costs to individuals, families and communities (WHO, 2002, 2013, 2014). The health sector plays a crucial role in multisector efforts responding to and preventing this violence (Garcia-Moreno et al., 2014; WHO, 2012). The provision of ‘high-quality care and support services to victims of violence is important for reducing trauma, helping victims heal and preventing repeat victimization and perpetration’ (WHO, 2014, p.8). In particular, this ‘high-quality care’, to mitigate the effects and long-term impact of sexual assault, includes responses that are timely, supportive, believing and that appropriately respond to the person who has experienced sexual assault.

The health system also has an important part to play in primary prevention (i.e. prevention of violence before it starts), through: documenting sexual assault, including publicising data about prevalence, health burden, and costs; advocating coordinated action with other sectors; and contributing to efforts to counter the acceptability of such violence (Garcia-Moreno et al., 2014). To be effective, there needs to be a focus on changing behaviours and social norms and structures rather than on awareness-raising (Quadara & Wall, 2012). NSW Health responses to sexual assault will be informed by understandings of the impact, extent and nature of these issues.

### **1.3 Promoting an integrated approach to violence, abuse and neglect**

‘Violence, abuse and neglect’ is used here as an umbrella term for three types of interpersonal violence that are widespread in the Australian community: all forms of child abuse and neglect, domestic and family violence, and sexual assault. While the dynamics in each sub-group can differ, there is a high degree of connection and overlap in the experience of, and responses to, these issues. There is also a substantial connection and overlap between violence, abuse and neglect and children and young people with PHSB. In NSW, there is currently a fragmented response, with each issue having its own history, philosophies, policies, services, practices and cultures. As a result, policy and service responses to violence, abuse and neglect have historically operated as silos for which there have been meetings at some intersections but not a consistent integrated response.

Women, men, children and young people may enter the NSW Health system with health issues that are either a direct or indirect consequence of violence, abuse and neglect. A history of violence, abuse and neglect is, however, usually not disclosed when presenting to a generalist health service. While presentations directly to specialist services (e.g. SASs) make the obvious link between experiences of violence, abuse and neglect and an individual’s health, there are significantly more health service presentations for these issues that are less straightforward. In many circumstances, the person may not have made the connection between their experiences of violence, abuse and neglect and the health complication they are seeking treatment for.

Further information and resources on violence, abuse and neglect, including definitions, statistics and research, priority populations, health consequences, public health

interventions, and infographics and fact sheets to help NSW Health workers understand and communicate relevant violence, abuse and neglect statistics and research accurately and succinctly, and to dispel myths, mistakes and misinformation about them, is available from the *Integrated Violence, Abuse and Neglect Statistics and Research Project* at: <http://www.ecav.health.nsw.gov.au/van-statistics-and-research/>.

The complexity of the prevalence, health impacts, causes, and responses to violence, abuse and neglect, and children and young people with PHSB, necessitates a whole-of-health-system response. Although responding to these issues is the responsibility of the whole health system, some services have a particularly important role to play in the prevention, identification and response to violence, abuse and neglect. This includes specific VAN services (e.g. SASs) which work across the spectrum of prevention and intervention, as well as targeted (secondary) and universal (primary) responses from a range of identified health services.

NSW Health is undertaking substantial work to integrate and reorient services, policies and clinical practice to ensure consistent and comprehensive responses to all forms of violence, abuse and neglect from violence, abuse and neglect-specific and mainstream health services, as well as child and adult services. This is part of a broader cultural shift towards person-centred, family-focused, trauma-informed, strengths-based and collaborative care and practice in NSW Health. This cultural shift recognises the important role that health systems play in addressing the adverse impact of violence, abuse and neglect on people's safety, health and wellbeing. Of particular note are:

1. efforts to communicate the responsibilities all NSW Health workers have regarding these issues, and build capacity in the broader health system to respond to violence, abuse and neglect with support from specialist services
2. realigning our specialist VAN services to ensure they have expertise and provide appropriate integrated responses to all forms of violence, abuse and neglect, and not solely those issues for which they have primary responsibility
3. the importance of health service prevention and intervention activities at all levels of the socio-ecological model (individual, relationship, community and society).

Further information about NSW Health's approach to integration and system redesign, as well as the evidence base underpinning this approach, is provided in the *Integrated Prevention and Response to Violence, Abuse and Neglect Framework* and *The Case for Change*, which are both available at:

<https://www.health.nsw.gov.au/parvan/Pages/van-redesign-program.aspx>

## **1.4 Use and structure of policy and procedures**

These policy and procedures provide directions, guidance and support to all NSW Health workers in providing services to people who have experienced sexual assault (adult and child) and their families, carers and significant others. They reflect the current point in time for NSW Health at the start of developing whole-of-health-system integrated ways of working in responding to violence, abuse and neglect. NSW Health continues to have specific SASs while, at the same time, developing varied innovative integrated work in



responding to violence, abuse and neglect across Local Health Districts (districts) and the Sydney Children's Hospitals Network (SCHN).

Reflecting this context, these document is structured in four main parts:

1. **Part one: Understanding the issues** (Sections 1-4) provides information and guidance to the whole NSW Health system on sexual assault. This includes an introduction to the issues and context for those unfamiliar with the prevalence and impact of sexual assault, as well as a framework for effective practice and reporting responsibilities for all NSW Health workers
2. **Part two: Responsibilities of specific NSW Health services, referral pathways and collaboration with Sexual Assault Services** (Sections 5-10) outlines the roles and responsibilities of the most common referrers and initial contact points in responding to sexual assault (adult and child), and how SASs receive referrals and work in collaboration with these referral sources. Specifically, this includes EDs, JCPRP/JRU, Department of Communities and Justice (DCJ), NSW Police Force (NSW Police), mental health services, and restricted settings (e.g. Corrections).
3. **Part Three: Sexual Assault Services responses** (Sections 11-21) provides information and clinical guidance on referral, intake and key roles and responsibilities of SASs and services provided to victims of sexual assault and their families/significant others. These sections are structured to reflect the SAS service model and a standard client service pathway through a SAS.
4. **Part Four: Sexual Assault Services management** (Sections 22-23) provides information on records, privacy and information sharing, governance and service management for SASs.

Figure 3 outlines the sections of these policy and procedures likely to be of most relevance to NSW Health services with specific responsibilities for responding to sexual assault. This table is intended as a guide only and does not limit NSW Health services that are not listed from drawing on the policy and procedures to inform clinical practice.

Key diagrams in this policy produced by NSW Health are available for download at:  
<https://www.health.nsw.gov.au/parvan/sexualassault/Pages/sexual-assault-policies.aspx>

As a NSW Health VAN service, SASs are expected to work with other forms of violence, abuse and neglect where these are secondary presenting issues. SASs are also the lead agency for NSW Health for children with PHSB. In addition to these policy and procedures, the clinical practice of SAS staff will therefore also be guided by relevant parts of NSW Health policy, including, but not limited to: the NSW Health policy on the Children's Sexual Behaviour Program; [Child Protection Counselling Service Policy and Procedures](#) and [Domestic Violence — Identifying and Responding](#). Although clinical practice with children with PHSB will be predominantly addressed in the relevant policy and procedures, as SASs are the lead agency for this client group, this policy and procedures occasionally mentions this group where relevant to demonstrate the interrelationship between SASs' responsibilities for both issues (e.g. concerning referrals to New Streets or priorities for client allocation).

**Figure 3: Use of these policy and procedures for different NSW Health services**

Service type	Service examples	Relevant responsibilities	Relevant part
Violence, abuse and neglect (VAN) services	Sexual Assault Services (SAS)	<ul style="list-style-type: none"> <li>• Sexual Assault Services</li> <li>• Sexual Assault Assessment Centres</li> <li>• Child Protection Units/Teams</li> <li>• Integrated VAN service (that includes sexual assault).</li> </ul>	All sections of the policy and procedures
	Other VAN services (apart from SAS)	<ul style="list-style-type: none"> <li>• Child Protection Counselling Services</li> <li>• Joint Referral Unit and Joint Child Protection Response Program Health workforce</li> <li>• New Street Services</li> <li>• Domestic and family violence Services</li> <li>• Child Wellbeing Units</li> </ul>	<a href="#">Part one</a> <a href="#">Part two</a> Referral to SAS ( <a href="#">Section 13</a> ) Ongoing therapeutic interventions ( <a href="#">Section 16</a> )
Secondary responses	Services with specific SAS referral pathways.	<ul style="list-style-type: none"> <li>• Emergency Departments</li> <li>• Mental Health (including Whole Family Teams)</li> <li>• Justice Health</li> </ul>	<a href="#">Part one</a> <a href="#">Part two</a> Referral to SAS ( <a href="#">Section 13</a> )
	Other targeted NSW Health services	<ul style="list-style-type: none"> <li>• Mental Health</li> <li>• Drug and alcohol</li> <li>• Community and Women's Health Centres</li> <li>• Generalist counselling services</li> </ul>	<a href="#">Part One</a> Referral to SAS ( <a href="#">Section 13</a> ) Ongoing therapeutic interventions ( <a href="#">Section 16</a> )
Primary responses	Universal services	<ul style="list-style-type: none"> <li>• Maternity and infant health services</li> <li>• Early childhood services</li> <li>• Paediatric services</li> <li>• Child and Family Services</li> <li>• Youth Services</li> <li>• Sexual Health Services</li> </ul>	<a href="#">Part one</a> Referral to SAS ( <a href="#">Section 13</a> )

## **1.5 Brief outline of Sexual Assault Services**

SASs provide free and confidential psychosocial, medical and forensic services to adult and child victims of sexual assault and children with PHSB (whether or not that child has experienced sexual assault), as well as the protective family, significant others and carers of these groups. These services address the safety, health and wellbeing needs of the client groups, including responding to emotional trauma and physical harm; address PHSB for children; and have implications for child protection and criminal justice responses through the provision of expert advice, collection of forensic evidence, and court preparation and support. They also provide professional consultation, training, community engagement, education and prevention regarding sexual assault and children with PHSB.

NSW Health has a network of specialist SASs delivered by districts/networks. These SASs operate 24 hours a day, seven days a week, and a contact list is available on the NSW Health website [here](#).<sup>3</sup> There are four main ways SASs may be organised by districts and the SCHN across the state:

1. SASs for victims of sexual assault and children with PHSB (regardless of whether or not the child is a victim of sexual assault), and their family/significant others.
2. Adult SASs for people 16 years and over and children 14-15 years old who have experienced assault by someone who is not a caregiver or relative (i.e. for whom there aren't substantial child protection concerns), as well as for their family/significant others.
4. CPUs for victims of sexual assault under the age of 16 years, children with PHSB, and the family/significant others of both groups.<sup>4</sup>
5. Integrated VAN services responding to more than one form of violence, abuse and neglect, including sexual assault and children with PHSB.

### **1.5.1 Client group**

SASs provide trauma-informed services for the following client groups:

- a. Children and young people:
  - o who have been sexually assaulted recently or in the past
  - o who are under 10 years old with PHSB as the primary presenting issue<sup>5</sup> (regardless of whether or not the child has experienced sexual assault)
  - o for whom a JCPRP health worker has identified, through a clinical assessment and consultation with interagency partners (NSW Police and/or DCJ), that they

<sup>3</sup> <http://www.health.nsw.gov.au/kidsfamilies/protection/Pages/health-sas-services.aspx>.

<sup>4</sup> When a child aged 14 or 15 years old meets the criteria for either an Adult SAS or a Child Protection Unit, the child will be given the choice of which service they would prefer to access.

<sup>5</sup> This refers to where PHSB is the main and significant concern of the referral and the child wouldn't be better referred to another service that may also address the PHSB where they also meet that service's service criteria (e.g. CPCS or CAMHS). See also the NSW Health policy on the Children's Sexual Behaviour Program for referral pathways for this client group.



may have been sexually assaulted or are likely to benefit from a SAS intervention.

- b. Adults sexually assaulted recently or in the past, including as a child.
- c. Family members/significant others (including carers) of both groups listed above.

No NSW Health service, including SASs, may treat young people 10-17 years old for their sexually harmful behaviour (other than New Street Services or in consultation with New Street Services as outlined in [Section 13.1.7](#) or forensic mental health services). No NSW Health Service, including SASs, may treat adults for their sexual offending, except forensic mental health services. These groups require specialist treatment approaches and their presence in SASs may compromise the safety of the SAS client group. Both groups may, however, be treated by other NSW Health services for other medical and health issues and, in doing so, NSW Health staff are to be aware of, and act upon, their reporting responsibilities as outlined in [Section 4](#). NSW Health workers will also refer these groups to appropriate services to address their sexually harmful behaviours and sexual offending respectively.

### **1.5.2 Scope of Sexual Assault Services**

The key services provided to the client groups listed above are integrated psychosocial and medical responses which aim to: respond to immediate and longer term health impacts of sexual assault; address safety and vulnerability especially in children; and assist to navigate the justice system to support victim rights and limit re-traumatisation. These services include:

- assessment of safety, immediate and ongoing support, and health care needs
- psychosocial services, including crisis and longer term counselling and other therapeutic interventions, provision of information, casework and client advocacy (including support with Victims Compensation applications)
- medical and forensic services, including examination, follow-up medical treatment for injuries or health concerns related to the assault, and collection of forensic evidence from victims
- court preparation, court support and reports, including Victim Impact Statements.

SASs also provide services to professionals and communities including:

- professional consultation and training
- systems advocacy
- community engagement and development, community education, awareness-raising, and prevention.

## 2 CONTEXT

### 2 Context: summary

- NSW Health responses to sexual assault and sexual abuse will be based on the best available evidence including: legal and policy definitions; sexual assault as a health issue; statistics; impacts; responsibility versus vulnerability and other perpetrator tactics; gendered nature; barriers to disclosure; and specific dynamics for children and young people.
- There is a range of relevant legislation, policies, charters and conventions that NSW Health workers will adhere to in responding to sexual assault and that inform these policy and procedures.

### 2.1 Framing the issues

#### 2.1.1 Definition of sexual assault and sexual abuse

Sexual assault occurs when a person is forced, coerced or tricked into sexual acts against their will or without their consent, or if a child or young person is exposed to sexual activities. The definition of sexual assault may vary in different contexts, however for this document the following definition from section 61I of the [Crimes Act 1900](#) is used: 'Any person who has sexual intercourse with another person without the consent of the other person'. In addition to outlining various types of sexual assault offences, the Act also outlines other sexual offences related to sexual assault including: sexual touching; various sexual offences against children including children — sexual assault, children — sexual touching, children — sexual act, children — procurement and grooming; and a range of other sexual offences.

Like sexual assault, sexual abuse with regard to children and young people has various definitions. However, for this document, the following definition from [Child Wellbeing and Child Protection Policies and Procedures for NSW Health](#) (p. 38) is used:

Sexual abuse is sexual activity or behaviour that is imposed, or is likely to be imposed, on a child or young person by another person. Sexual activity includes the following: sexual acts; exposure to sexually explicit material; inducing or coercing the child or young person to engage in, or assist any other person to engage in, sexually explicit conduct for any reason and exposing the child or young person to circumstances where there is risk that they may be sexually abused.

'Sexual assault is a crime of violence with serious consequences and requires specialist intervention' (NSW Police, NSW Health & ODPP, 2006).

#### 2.1.2 The nature of sexual assault

A very brief summary of some of the key issues and evidence on the nature of sexual assault is provided below and outlined in a little more detail in [Appendix 1](#). It is beyond the scope of these policy and procedures to provide a detailed analysis of the evidence. However, it is important for clinicians to be informed by the evidence on the nature of sexual assault. Further resources and training of value for NSW Health workers related to

sexual assault in addition to those provided here can be sourced from NSW Health's [Education Centre Against Violence](http://www.ecav.health.nsw.gov.au/van-statistics-and-research/) (ECAV). This includes *The Integrated Violence, Abuse and Neglect Statistics and Research Project* at <http://www.ecav.health.nsw.gov.au/van-statistics-and-research/>, which provides statistics and research on sexual assault and child sexual abuse in Australia, including characteristics of sexual assault, the experiences of specific priority population groups, and health outcomes.

- **Statistics on sexual assault:** Sexual assault is widespread in the Australian community, with many people affected, particularly women, young women and girls. For example, since the age of 15, approximately one in nine Australians (11.7% or 2.2 million) experienced sexual violence, including one in five women (18% or 1.7 million) and one in 20 men (4.7% or 428,800) (ABS, 2017).
- **Impacts of sexual assault:** The impact of sexual assault on the lives of people who experience it is multifaceted and complex and may include emotional, social, psychological, neurobiological, legal, health, spiritual, economic and political consequences. A growing body of research has demonstrated that sexual assault can have a range of immediate and lifelong effects on physical and mental health (see for example AIHW, 2018; Briere & Spinazzola, 2005; Cashmore & Shackel, 2013; Royal Commission, 2017; Sturza & Campbell, 2005; Ullman, Filipas, Townsend & Starzynski, 2005; Wadsworth & Records, 2013; WHO, 2013b). Sexual assault affects people differently and the nature and extent depends on many factors.
- **Responsibility versus vulnerability and other perpetrator tactics:** Perpetrators use a range of deliberate strategies and tactics against both adults and children to facilitate the sexual assault, minimise the nature, extent or impact of their violence, and invalidate the experiences and credibility of their victims (Costello, 2009). This includes blurring the difference between responsibility and vulnerability. The nature of these strategies and tactics can significantly impact on a victim's wellbeing and operate to shift shame, guilt and responsibility for a sexual assault from the perpetrator to the victim.
- **Gendered nature of sexual assault:** sexual assault is gendered, meaning that the majority of victims are female, the vast majority of perpetrators are male, and gendered differences in victimisation experience exist. In addition, sexual assault is underpinned by gender inequality and acts to express and reinforce gendered power relations regardless of the gender identity of the victim or perpetrator.
- **Barriers to disclosure:** there may be a range of barriers, including ongoing risk, or related to relationship and risk from fear of the perpetrator, which may prevent people from seeking help to overcome the effects of the assault or to report it to the police.
- **Specific dynamics for children and young people:** particularly related to the relationship between the perpetrator and child and the abuse of trust, authority and power over the child, which make it particularly difficult for children to identify and name their experiences as abuse.

## **2.2 Legislative and policy context**

NSW Health workers operate within a broad range of NSW and Commonwealth legislation and provide services in response to sexual assault in accordance with Commonwealth and NSW Government (including NSW Health) policy as well as national and international charters and conventions. Legislation, policies, charters and conventions of particular relevance are listed below and [Appendix 2](#) provides a brief commentary on what they include.

### **2.2.1 Legislation**

- [\*Children and Young Persons \(Care and Protection\) Act 1998\*](#)
- [\*Children \(Criminal Proceedings\) Act 1987\*](#)
- [\*Child Protection \(Working with Children\) Act 2012\*](#)
- [\*Crimes Act 1900 \(NSW\)\*](#)
- [\*Crimes \(Domestic and Personal Violence\) Act 2007\*](#)
- [\*Crimes \(Forensic Procedures\) Act 2000\*](#)
- [\*Crimes Act 1914 \(Cth\)\*](#)
- [\*Evidence Act 1995\*](#)
- [\*Family Law Act 1975 \(Cth\)\*](#)
- [\*Guardianship Act 1987\*](#)
- [\*Health Practitioner Regulation National Law 2009\*](#)
- [\*Health Records and Information Privacy Act 2002 \(HRIP Act\)\*](#)
- [\*Health Services Act 1997\*](#)
- [\*Mental Health Act 2007\*](#)
- [\*Ombudsman Act 1974\*](#)
- [\*Victims Rights and Support Act 2013\*](#).

### **2.2.2 Policies**

- [\*Child Related Allegations, Charges and Convictions Against NSW Health Staff\*](#)
- [\*Child Wellbeing and Child Protection — NSW Interagency Guidelines\*](#)
- [\*Child Wellbeing and Child Protection Policies and Procedures for NSW Health\*](#)
- [\*Domestic Violence — Identifying and Responding\*](#) (NSW Health)
- [\*Identifying and responding to abuse of older people\*](#) (NSW Health)
- [\*Integrated Prevention and Response to Violence, Abuse and Neglect Framework\*](#) (NSW Health)
- [\*Managing Complaints and Concerns About Clinicians\*](#)
- [\*Managing Misconduct\*](#)
- [\*NSW Health Privacy Manual for Health Information\*](#)
- *NSW Police, Health, and Office of the Director of Public Prosecutions Guidelines for responding to adult victims of sexual assault*
- [\*Photo and video imaging in cases of suspected child sexual abuse, physical abuse and neglect\*](#) (NSW Health)
- [\*Sexual Safety — Responsibilities and Minimum Requirements for Mental Health Services\*](#) (NSW Health)
- [\*Sexual Safety of Mental Health Consumer Guidelines\*](#) (NSW Health)

- [Subpoenas](#) (NSW Health)
- [Your Health Rights and Responsibilities](#) (NSW Health)
- [National Framework for Protecting Australia's Children 2009-2020](#)
- [National Plan to Reduce Violence against Women and their Children 2010-2022](#)
- [National Principles for Child Safe Organisations](#)
- [National Risk Assessment Principles for Domestic and Family Violence](#)

### **2.2.3 Charters and Conventions**

- [Australian Charter of Healthcare](#)
- [NSW Charter of Victims Rights](#)
- [NSW Code of Practice for the Charter of Victims Rights](#)
- [United Nations Convention on the Rights of The Child](#)
- [United Nations Declaration on the Elimination of Violence against Women](#)
- [World Health Assembly Resolution WHA49.25: Prevention of violence: a public health priority](#)

## **2.3 Interagency context**

Services for adults, children and young people who have been sexually assaulted are provided by a number of different government and non-government agencies. Government agencies besides NSW Health with particular responsibilities in these areas include:

- Department of Communities and Justice (DCJ), which undertakes risk, safety and needs assessments and interventions for children or young people and families, to ensure their safety, welfare and wellbeing.
- NSW Police, which conducts criminal investigations of allegations of sexual assault and criminal child abuse and neglect.
- Office of the Director of Public Prosecutions (ODPP), which conducts criminal and related proceedings with respect to sexual assault matters.
- Victims Services, which provides support, information, referrals, counselling and compensation services to victims of violent crimes and witnesses to violent crimes.

In addition, a number of non-government organisations (NGOs) provide services to these groups.

Local procedures and protocols for responding to sexual assault must comply with centrally determined guidelines for government agencies, including:

- *NSW Police, Health, and ODPP Guidelines for responding to adult victims of sexual assault* (NSW Police, NSW Health & ODPP, 2006).
- [Child Wellbeing and Child Protection — NSW Interagency Guidelines](#).
- *Joint Child Protection Response Program Statement of Intent, September 2018*
- [NSW Charter of Victims Rights](#)

### 3 FRAMEWORK FOR EFFECTIVE PRACTICE

#### 3 Framework for effective practice: summary

- There are a number of principles of intervention that all NSW Health workers will observe when responding to sexual assault (adult and child).
- NSW Health workers and services will adhere to the operational requirements for Child Safe Organisations.
- Responses to sexual assault, particularly from SASs and other VAN services, will be underpinned by key practice approaches, including: trauma-informed, trauma-specific and violence-informed; collaborative practice and integrated service delivery; child and family-focused, including working with families as a whole and working in partnership with families; strengths-based; and critically reflective practice.
- All people who have experienced sexual assault will be assessed and responded to on an individual basis, no matter which community they belong to, or how they identify. Nevertheless, additional barriers and unique experiences for certain population groups mean that NSW Health workers and services will take into particular account the specific needs of these groups.

#### 3.1 Applying the socio-ecological model to responses to sexual assault

NSW Health conceptualises sexual assault as violence, a trauma, a crime, a violation of human rights, and a serious social issue that may have short and long-term health impacts for the victim and collective impacts on the broader community. Sexual assault requires a range of evidence-based responses and interventions that meet the potentially complex safety, psychological, social, legal, medical and forensic, education and information needs of clients, professionals and communities.

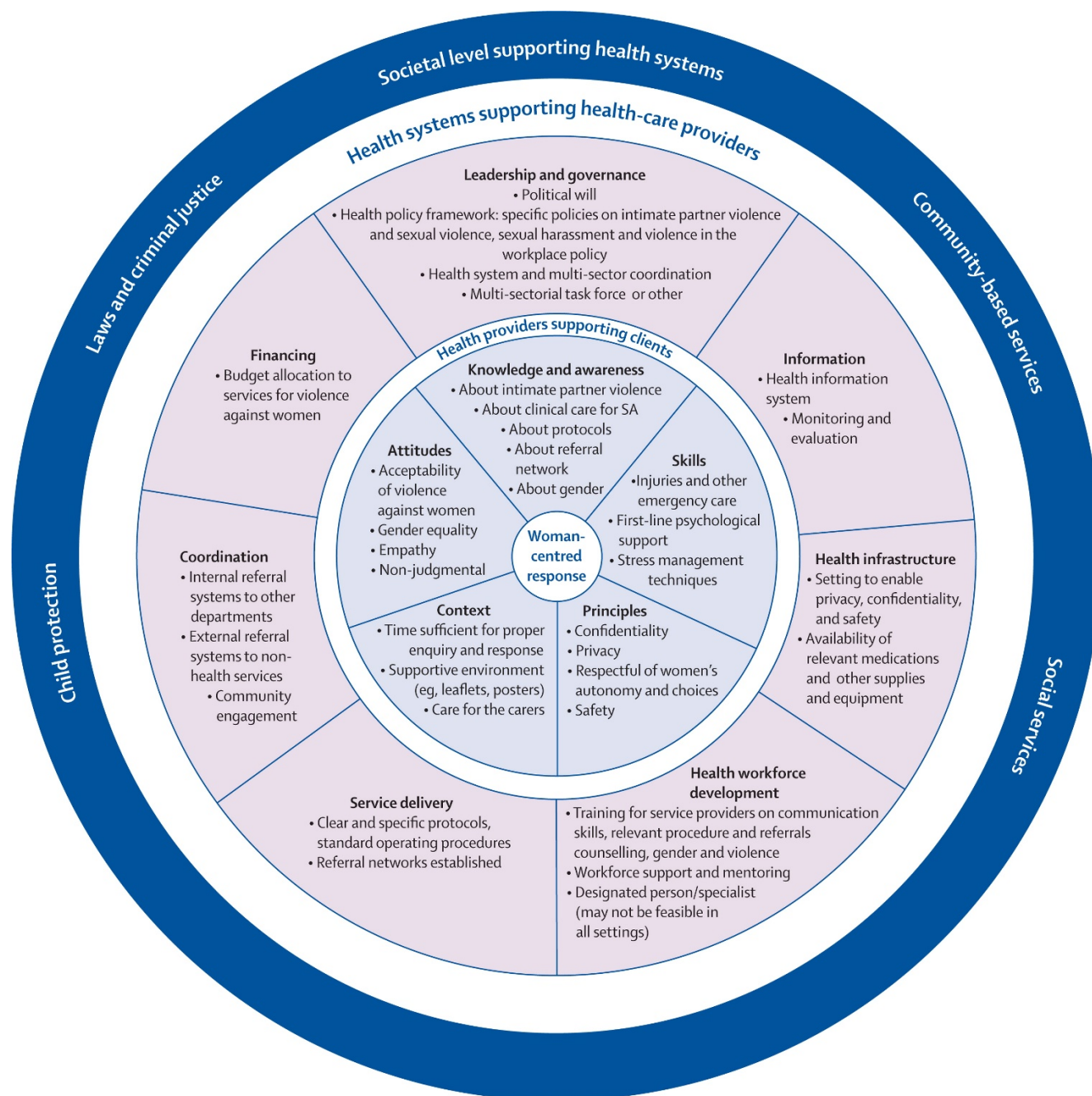
SASs provide an integrated holistic and multi-disciplinary response to sexual assault informed by socio-ecological, victim-centred and feminist perspectives that acknowledge the social pattern of inequality in which sexual assault is perpetrated, and underpin a social justice framework for practice. This includes consideration of gender, culture, ethnicity, age, sexuality, religion, ability/disability and socio-economic status.

To be effective, SASs need to be located within a supportive, collaborative and person-centred, whole-of-health-system and multi-sectoral approach. Figure 4 below provides an overview of the necessary elements of a comprehensive systems approach to violence against women, which is equally applicable to responses to sexual assault more broadly for women, men and children.



**Figure 4: Elements of the health system and health-care response necessary to address violence against women**

Reprinted from *The Lancet* 385, Garcia-Moreno, et al, *The health-systems response to violence against women*, p. 1570 © 2014 with permission from Elsevier; adapted from Colombini et al. *BMC Public Health* 2012, 12:548.



### **3.2 Principles of intervention**

All NSW Health service responses to sexual assault will be underpinned by the following principles of intervention:

1. People are entitled to high-quality, timely, accessible, effective and evidence-informed interventions to ameliorate the health outcomes of sexual assault. The key focus of the NSW Health response to sexual assault is the health, safety and wellbeing of the client and those around them.
2. Timely and appropriate intervention at the time of the sexual assault or disclosure of sexual assault is the most valuable response to support recovery, increase safety and prevent longer-term health problems.
3. The safety, welfare and wellbeing of children, young people and adults are paramount and services work individually and systematically to achieve this goal.
4. People have a right to a service response that recognises the needs of diverse communities, responds in culturally safe ways, and facilitates access to services.
5. Interventions recognise that abuse of power and loss of control are inherent in sexual assault and so therapeutic interventions must be respectful, supporting the client's control and choice, and building their resilience.
6. Interventions will: validate the person's experience; be non-judgemental; not make assumptions about what the person needs; offer choices and alternatives; seek informed consent; be open, honest and respectful; and be guided by the person, including in addressing their stated priorities.
7. Strength and resilience-based interventions that promote and prioritise safety, dignity, respect and wellbeing provide the most effective interventions.
8. Positive outcomes for children, young people and adults are achieved through the development of relationships with family members, carers and significant others who recognise their strengths and are responsive to their needs.
9. Aboriginal and Torres Strait Islander people and communities should participate in decision-making concerning the care and protection of their children and young people where it is safe and appropriate to do so.
10. As sexual assault is often associated with shame and stigma, services will apply various strategies to improve access and engage with people.
11. The victim is never responsible for sexual assault.
12. Services will observe the principles of child-aware and child-specific approaches, including service provision which is: family sensitive, child-inclusive, age and developmentally appropriate, supportive of the child's right to be involved in decision-making, culturally competent, collaborative and strengths-based.
13. Strong interagency partnerships (government and non-government), collaborative practice and effective communication lead to better outcomes.
14. All NSW Health workers will be well-trained, supported, trauma-informed and clinically supervised, and NSW Health VAN services will be trauma-specific, violence-informed and adequately resourced.



### 3.3 Child Safe Standards — organisational requirements

The United Nations Convention on the Rights of the Child obliges institutions providing services to children to act in the best interests of the child as their primary consideration. In response to recommendations made by the [\*Royal Commission into Institutional Responses to Child Sexual Abuse\*](#) (the Royal Commission), NSW Health has affirmed its commitment to ensuring that *all* its services, including those whose primary clients are adults, uphold the rights of children and are 'child safe'. All NSW Health staff, with support from districts, networks, pillars and Statutory Health Corporations, are expected to promote and facilitate child safety within their organisational context through implementation of the Standards for Child Safe Organisations.

A 'child-safe organisation' is one that takes deliberate steps to create and embed workplace cultures, adopt strategies and take actions to promote child wellbeing and prevent harm to children and young people. More specifically, a child-safe organisation is one that:

- creates an environment where children's safety and wellbeing is the centre of thought, values and actions
- places emphasis on genuine engagement with and valuing of children
- creates conditions that reduce the likelihood of harm to children and young people
- creates conditions that increase the likelihood of identifying any harm
- responds to any concerns, disclosures, allegations or suspicions of harm (Australian Human Rights Commission, 2018, p. 3).

**Figure 5: Child Safe Standards**  
(reproduced from Royal Commission, 2017, Vol. 6, p. 145)



The standards are:

1. Child safety is embedded in institutional leadership, governance and culture.
2. Children participate in decisions affecting them and are taken seriously.
3. Families and communities are informed and involved.
4. Equity is upheld and diverse needs are taken into account.
5. People working with children are suitable and supported.
6. Processes to respond to complaints of child sexual abuse are child-focused.
7. Staff are equipped with the knowledge, skills and awareness to keep children safe through continual education and training.
8. Physical and online environments minimise the opportunity for abuse to occur.
9. Implementation of the Child Safe Standards is continuously and regularly reviewed and improved.
10. Policies and procedures document how the institution is child-safe.

The 10 Child Safe Standards identified by the Royal Commission are designed to be 'high level' and flexible enough to support localised implementation and recognise a range of organisational types, sizes and capacities. These standards are incorporated in, and underpin, the [National Statement of Principles for Child Safe Organisations](#).

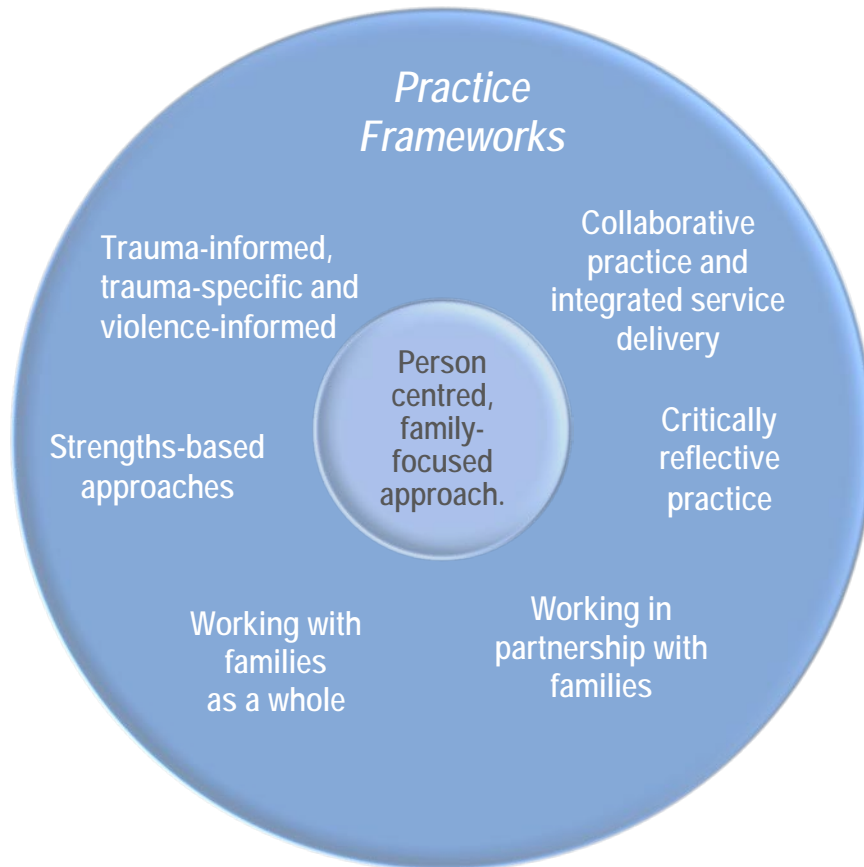
More detail about the standards and how these may be applied by SASs in practice is provided in [Appendix 3](#)

### **3.4 Key practice approaches for responding to sexual assault**

It is critical that practice with people who have experienced sexual assault and their families/significant others is guided by sound theoretical underpinnings and practice approaches, which are often seen as the formal knowledge base for practice. This helps practitioners work in inclusive and anti-oppressive ways with children and families, resisting practice that is based on assumptions and stereotypes (Collingwood, Emond, & Woodward, 2008). The key practice frameworks listed below and represented in Figure 6 underpin the guidance on clinical interventions in the remainder of these policy and procedures, and may therefore also guide practitioners in their work with children with PHSB and their families:

- trauma-informed, trauma-specific and violence-informed approaches
- collaborative practice and integrated service delivery
- child and family-focused, including working with families as a whole and working in partnership with families
- strengths-based approaches
- critically reflective practice.

Figure 6: Key practice frameworks for responding to sexual assault (adult and child)



More information about each of these practice frameworks is provided in [Appendix 4](#).

### 3.5 Considerations for working with specific populations

Violence, abuse and neglect are experienced by individuals and families across all of Australia's communities. There is sufficient evidence to suggest, however, that particular groups of people experience multiple challenges that may heighten the likelihood, impact or severity of violence, as well as experiencing additional and specific barriers to seeking support and securing safety related to intersecting identity-based and situational factors and experiences of discrimination (AIHW, 2018a; Royal Commission into Institutional Responses to Child Sexual Abuse, 2017).

Best practice in all responses to sexual assault must be inclusive of those who experience significant disadvantage and discrimination, and be responsive to differing needs and contexts. Consideration is needed for the experiences and needs of specific population groups whose unique experiences see them facing additional barriers or for whom a specific response is required.

In this context, an intersectional approach to interventions, prevention and engagement is key. 'Intersectional' or 'intersectionality' as it is used here refers to the conceptual framework that seeks to understand the dynamics of different and often co-occurring identity-based and situational factors and structures of oppression experienced by

individuals from diverse communities, and the unique safety risks and sometimes competing needs to which these factors contribute (Backhouse and Toivonen, 2018).

For NSW Health workers to take an intersectional approach in practice means recognising and responding to barriers to seeking support, and the particular forms of violence and fears that people from some groups experience. An intersectional approach includes understanding that these fears and experiences are not only driven by sexism and gender inequality, but also by experiences of other forms of discrimination, including racism, ableism (discrimination in favour of able-bodied people) and homophobia (Chen, 2017; The Equality Institute, 2017). It is important to note that:

No one factor is singularly causal for violence and abuse and, in practice, all people who have experienced sexual assault should be assessed and responded to on an individual basis, no matter which community they belong to, or how they identify. Further, target groups for violence prevention initiatives will be specific to local contexts. However, developing a shared understanding of the additional barriers and unique experiences some people may face is important to inform appropriate integrated responses, allocation of resources and targeted outreach activities. (Costello & Backhouse, 2019a)

Accordingly, NSW Health workers will in particular consider the specific needs of the groups listed below when responding to sexual assault. Information about the needs of these groups is provided throughout the policy as relevant to practice in specific circumstances, as well as in [Appendix 5](#), which provides a more detailed discussion to guide practice focused on those groups that is not explicitly addressed elsewhere in the policy and procedures.

- Aboriginal people and communities
- Lesbian, gay, bisexual, transgender, queer and intersex (LGBTQI) people
- People with disability
- Culturally and linguistically diverse people, migrants and refugees
- People living in rural, regional and remote areas
- Children and young people, particularly those in OOHHC.
- Adult survivors of child sexual assault
- Older people
- People experiencing domestic and family violence
- People with a mental illness
- People involved with the Family Court
- Families and children involved with Children's Court
- People with substance use and dependence issues
- Sex workers
- People in restricted settings (correctional or secure inpatient facilities).

## 4 REPORTING RESPONSIBILITIES

### 4 Reporting responsibilities: summary

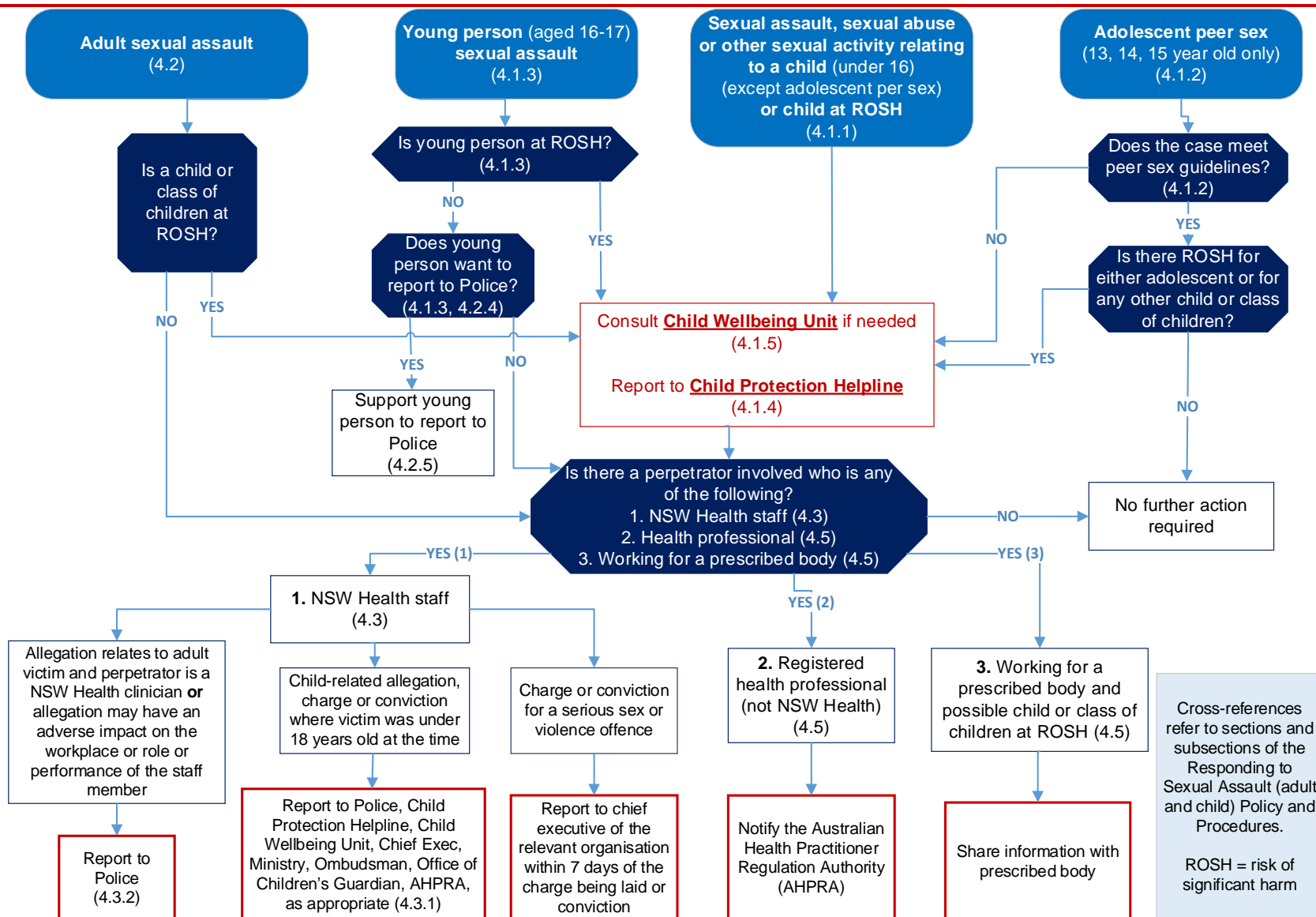
- NSW Health workers will report and record child protection concerns to the [Child Protection Helpline](#) in accordance with relevant legislation and NSW Health policy ([Section 4.1](#)).
- NSW Health workers will consider who else to consult with when deciding whether a report to the [Child Protection Helpline](#) is required. The [NSW Health Child Wellbeing Unit](#) may be able to assist in this decision.
- Although some obligations to report sexual assault to NSW Police exist under sections 316 and 316A of the [Crimes Act 1900](#), this Act also recognises the role certain NSW Health workers play in the care of victims of crime and the value of confidentiality within a therapeutic health relationship ([Section 4.2.1](#)).
- NSW Health workers will report sexual assault to NSW Police in accordance with specific policy requirements including where urgent involvement is required ([Section 4.2.4](#)), with consent ([Section 4.2.5](#)), or when supporting adults with alternative reporting options ([Section 4.2.6](#)).
- In making and responding to a report of an allegation of sexual assault by another NSW Health worker, NSW Health workers will adhere to NSW Health's policies with particular attention to: [Child Related Allegations, Charges and Convictions against NSW Health Staff](#); [Child Wellbeing and Child Protection Policies and Procedures for NSW Health](#); [Managing Complaints and Concerns about Clinicians](#); and [Managing Misconduct](#) ([Section 4.3](#)).
- NSW Health workers will follow the [Sexual Safety of Mental Health Consumer Guidelines](#) where a mental health consumer reports sexual assault ([Section 4.4](#)).
- NSW Health workers will notify the appropriate authority if they are made aware of an allegation of sexual assault or sexual misconduct where the alleged perpetrator is a registered health practitioner or works for a prescribed body ([Section 4.5](#)).

The following section provides guidance on sexual assault–related reporting responsibilities for all NSW Health workers, which may arise at any stage of an interaction or intervention once the worker has identifying information about a person or group of people (e.g. a group of children at risk from a perpetrator). An outline of key reporting requirements is in the flowchart at Figure 7.

When working with any client, NSW Health workers will advise the client about both confidentiality requirements and the limitations of confidentiality in certain circumstances, including concerning child protection, NSW Police and other reporting obligations.

## Responding to Sexual Assault (Adult and Child) Policy and Procedures

**Figure 7:**  
Flowchart of  
key reporting  
responsibilities  
for NSW Health  
staff related to  
sexual assault





## **4.1 Reporting to the Child Protection Helpline**

### **4.1.1 General child protection reporting guidelines**

Where a NSW Health worker has reasonable grounds to suspect that a child or young person is at risk of significant harm, section 27 of the [Children and Young Persons \(Care and Protection\) Act 1998](#) (the CYPCP Act) requires them to make a report to Department of Communities and Justice (DCJ). Risk of significant harm refers to where current concerns exist for the safety, welfare or wellbeing of the child or young person because of the presence, to a significant extent, of any one or more of the circumstances detailed in Section 23 of the CYPCP Act. These circumstances include the likelihood that a child or young person may suffer physical, psychological or emotional harm as a result of what is done (e.g. physical, sexual, emotional abuse or living in a household where there is domestic and family violence) or not done (e.g. neglect) to the child or young person by another person, often an adult responsible for their care. Risk of significant harm can also refer to a child or young person who may suffer physical, psychological, sexual or emotional harm as a result of environmental factors (e.g. homelessness) or self-harming behaviours.

Prior to making a report, NSW Health workers will consult the online [Mandatory Reporter Guide](#) (MRG) on the ChildStory website, because following the MRG outcome has been shown to increase the likelihood of an appropriate ROSH report being made. It is important to note, however, that the MRG is a tool, and professional judgement can override the MRG, particularly where the worker has ongoing ROSH concerns.

Section 27A of the CYPCP Act enables NSW Health workers (and certain other mandatory reporters) to report (via telephone or eReport) to the [NSW Health Child Wellbeing Unit](#) (CWU) as a legal alternative to reporting to the Child Protection Helpline. When a worker reports concerns to the CWU and the CWU appraises that a report to Helpline is indicated, if agreed, the CWU may eReport directly on the health worker's behalf. The CWU can also assist in assessing the level of risk and detecting patterns of neglect and/or cumulative harm via their direct access to the shared ChildStory client database, particularly when you are undecided as to whether any new information should be reported.

NSW Health workers are required to adhere to the [Child Wellbeing and Child Protection Policies and Procedures for NSW Health](#). Specifically, concerning sexual assault they will note:

- If the matter concerns sexual abuse, or any sexual activity with the exception of 'adolescent peer sex' (see discussion below), for a child under the age of 16 (or class of children or young people), you must report to the [Child Protection Helpline](#).
- If the matter concerns sexual abuse for a young person aged 16 or 17 years old, you must consider whether there are any concerns that the young person (or class of children or young people) is at risk of significant harm and, if so, you must report to the [Child Protection Helpline](#) (see [Section 4.1.3](#)).

A report made to the [Child Protection Helpline](#) or CWU must be documented in the health record in accordance with [Child Wellbeing and Child Protection Policies and Procedures for NSW Health](#).

### **4.1.2 Adolescent consensual peer sex**

The term 'adolescent consensual peer sex' refers to where:

- the adolescent is aged 13, 14 or 15, **AND**
- the adolescent's sexual partner is within two years of age of the adolescent, **AND**
- both the adolescent and their sexual partner 'consents' to the sexual activity. 'Consent' refers to the general meaning of that term — that is, both parties understand the nature of the activity and freely agree to participate in a context where there is mutual agreement, equality between both adolescents (e.g. one does not have a position of authority over the other), and there is no coercion or pressure to comply, **AND**
- neither individual has any condition that impairs the individual's cognitive capacity, irrespective of the cause or duration of that condition (e.g. intellectual disability, under the influence of a substance, brain injury, mental health episode or disorder, and others).

On its own, 'adolescent consensual peer sex' does not necessarily indicate suspected ROSH and require a report to the Child Protection Helpline. Rather, the NSW Health worker must exercise their professional judgement to determine whether they suspect an adolescent engaging in consensual peer sex has been, or is likely to be, at risk of significant harm.

Professional judgement requires consideration of all relevant factors to determine whether the adolescent is at risk of significant harm, including the age of the adolescent, the age of the adolescent's sexual partner, the maturity of the adolescent and the circumstances of the incident, particularly whether there is any indication of abuse (including psychological abuse) or ill treatment. If, after considering these factors, the NSW Health worker's professional judgment is that the adolescent is suspected to be at risk of significant harm, a report must be made to the Child Protection Helpline in accordance with NSW Health child protection policy. This professional judgement may be assisted with reference to the [Mandatory Reporter Guide](#). Where no such suspicion of risk of significant harm arises, there is no obligation for NSW Health workers to report to the Child Protection Helpline.

#### **4.1.3 Young people aged 16 and 17 years old**

Although the CYPCP Act provides some discretion about reporting young people aged 16 or 17 years old, NSW Health workers will complete the MRG and report to the [Child Protection Helpline](#) when they suspect the young person aged 16 or 17 years is at risk of significant harm and follow the general guidelines above.

Not all young people (16 and 17 year olds) presenting to NSW Health services following sexual assault will be at risk of significant harm for the purposes of the CYPCP Act, and therefore not all presentations must be reported. NSW Health workers should apply professional judgement in deciding whether concerns about the safety, welfare or wellbeing of a young person aged 16 or 17 years old (or class of children or young people) warrant a report to the [Child Protection Helpline](#).

NSW Health workers should also consider who else to consult with (e.g. [CWU](#)) when deciding whether a report to the [Child Protection Helpline](#) is required. The CWU may be able to provide additional information on ChildStory that could reveal a past history relevant to the victim's current safety and wellbeing or the alleged perpetrator that may impact on the worker's assessment about whether the young person is at risk of significant harm.

Factors that are relevant for consideration will vary for each young person (16 or 17 years old) and may include:

- whether their parents or guardians are aware of the sexual assault
- the circumstances of the assault
- whether there may be another child or young person or class of children or young people who are at risk from the same perpetrator/s.

When working with a young person aged 16 or 17 years old, NSW health workers will:

- involve the young person in the decision to make the report and the process of reporting, unless there are exceptional reasons for excluding them
- inform the [Child Protection Helpline](#) if the young person does not agree to the report being made so they can consider the young person's wishes in any investigations and assessments.

When reporting, workers will ensure they provide as much information as possible about the young person's current circumstances, including who is aware of the abuse. This will assist DCJ and/or NSW Police in determining how to proceed with an investigation, including supporting the ongoing safety of the young person. For example, if the young person has not disclosed to any family member that sexual abuse that has occurred outside of their household, then it is important that the report includes this information. This will enable investigators to be sensitive to the young person's concerns about who may be informed of the abuse and when this might occur.

Where a worker decides not to make a report to the [Child Protection Helpline](#) of a young person who has experienced sexual assault, the factors that were considered and the reason for this decision must be documented in the client's file.

## **4.2 Reporting to the NSW Police Force**

Although sexual assault is a crime, as a general principle, SASs must respect the wishes of an adult or young person (16 or 17 years who is not at risk of significant harm — see Section 4.1.3 above) who has experienced sexual assault as to whether they proceed with a formal report to NSW Police. There are exceptions to this where a NSW Health worker has a legal and/or policy obligation to report information to NSW Police or other agencies. This includes where:

- the NSW Health worker has information that would be of material assistance to NSW Police in relation to a serious indictable offence ([Section 4.2.1](#))
- the victim is a mental health consumer (see [Section 4.4](#))
- where the allegation involves notifiable conduct by a health worker or the alleged perpetrator is one of the types of professionals identified in [Section 4.5](#).

### **4.2.1 Reporting information about a serious criminal offence to NSW Police Force**

The [Crimes Act 1900](#) creates an offence for an adult to withhold information from NSW Police about a 'serious indictable offence' (section 316) or a 'child abuse offence' (section 316A) without a reasonable excuse where they have information that might be of material assistance to NSW Police in apprehending, prosecuting or convicting the offender. A serious indictable offence is an offence that carries a term of imprisonment for five years or more and includes any form of assault that causes actual bodily harm, including scratches and bruises. A 'child abuse offence' under the [Crimes Act 1900](#) includes serious physical assault as well as sexual abuse of a child under the

age of 16 years. Penalties for concealing a 'serious indictable offence' or 'child abuse offence' without a reasonable excuse include imprisonment

NSW Health workers do not have to report information about a child abuse offence to NSW Police if they have already reported the information to the [NSW Health CWU](#) or [Child Protection Helpline](#), or they believe on reasonable grounds that another person has. This is a 'reasonable excuse' for not reporting the information to NSW Police. Other examples of reasonable excuses for not reporting the information about a child abuse offence to NSW Police include:

- if the alleged victim is an adult at the time of providing the information and doesn't want it reported to NSW Police
- the person has grounds to fear for their safety or another person's safety if they report to NSW Police.

The [Crimes Act 1900](#) also recognises the role certain NSW Health workers play and the value of confidentiality within a therapeutic health relationship with adult clients/patients by requiring approval prior to prosecuting these NSW Health workers. Prosecutions cannot be sought under sections 316 and 316A against the professions prescribed in the regulations (which includes a medical practitioner, psychologist, nurse, social worker, support worker for victims of crime, and counsellor who treats persons for emotional or psychological conditions suffered by them) if that information was obtained while undertaking their role without the consent of the NSW Director of Public Prosecutions.

In the interagency *Guidelines for Responding to Adult Victims of Sexual Assault* (NSW Police, NSW Health & ODP, 2006) decisions about whether to report a sexual assault to NSW Police for adults and young people (16-17 years old) who have experienced sexual assault rests with the victim. An exception to this is where the NSW Health worker has a legal or policy obligation to report the information to NSW Police as described elsewhere in this section. Where a NSW Health worker is complying with interagency guidelines and this policy and procedures document, NSW Health expects approval would not be granted to prosecute the Health workers prescribed in the regulations (as listed above). If NSW Health workers are concerned about information they have in relation to an incident that they believe may require them to report to NSW Police under sections 316 or 316A of the [Crimes Act 1900](#), they will consult their manager and/or NSW Health Legal.

If an adult or young person (who is not at risk of significant harm) who has experienced sexual assault chooses not to make a report to NSW Police or proceed through the criminal justice system, this will not impact on their ability to receive a NSW Health service.

#### **4.2.2 Specific obligations relating to children less than 16 years of age**

When a NSW Health worker makes a report to [Child Protection Helpline](#) they are not required to make a separate report to NSW Police. However, in some circumstances, such as when a child presents after hours and there is an urgent need to collect physical evidence, and JCPRP are not available, SAs may directly contact the Police to report a sexual assault. If NSW Police are involved but no report has been made to the [Child Protection Helpline](#) regarding the matter, the NSW Health worker will report to the Helpline in accordance with [Section 4.1](#).

#### **4.2.3 Specific obligations relating to young people aged 16 and 17 years**

If a NSW Health worker makes a report to the [Child Protection Helpline](#) about a young person ([Section 4.1.3](#)), they will confirm whether DCJ intends to notify NSW Police. If a report has not

been made to the Helpline and NSW Police are not involved, the SAS staff will discuss the option of reporting to NSW Police with the young person. Unless there are concerns about risk of significant harm, or the NSW Health worker has a legal or policy obligation to report the information to NSW Police as described elsewhere in this section, the decision to report remains with the young person. If a young person decides to report to NSW Police, the SAS staff will provide support to them to do this ([Section 4.2.5](#)).

#### **4.2.4 Urgent NSW Police involvement**

In cases where urgent NSW Police action is required to protect a child (e.g. to prevent a perpetrator removing a child from the hospital), then the urgent contact will be made with NSW Police. NSW Police can assume care of a child or young person in an emergency situation.

Urgent contact with NSW Police may also be required for adults. For example, this may be to prevent a perpetrator forcibly removing an adult victim of sexual assault or domestic and family violence from a NSW Health service or in the case of a serious threat.

#### **4.2.5 Process to assist a victim to report to NSW Police**

SAS counsellors will provide clear and accurate information in an unbiased manner about reporting options available to adults and young people who have experienced sexual assault. SAS counsellors will:

- inform the victim of all of the reporting options available to them, including options for reporting to NSW Police
- explain to the victim their right to make a statement to NSW Police or not. A statement may enable NSW Police to investigate the crime with the possibility of a perpetrator being charged
- explain to the victim that, depending on the circumstances and the timing of the sexual assault, NSW Police may request that the victim undergo a medical and forensic examination. The victim is not obliged to comply with this request, but they will be provided with information to assess the benefits of undergoing a medical and forensic examination.
- provide information about a medical and forensic examination, the steps involved in releasing the Sexual Assault Investigation Kit (SAIK) and a brief outline of what NSW Police do in responding to sexual assault
- comply immediately with any request by the victim to talk to or inform NSW Police. Staff will explain that delays in notifying the Police could impair the investigation and reduce the likelihood of the perpetrator being apprehended and charged
- if necessary, provide the victim with further information and counselling to assist them to decide whether they wish to report the sexual assault to NSW Police
- provide support to victims who decide to report to NSW Police.

Victims of historical sexual assault may also attend SASs for counselling. This includes adult survivors of child sexual assault. In the course of that counselling they may decide to make a report to NSW Police regarding these sexual assaults. The sexual assault worker will support the victim in making that report.



Although the process of participating in a police investigation and court proceedings can be traumatic for victims, receiving formal recognition of the crime they have experienced may be extremely important.

#### **4.2.6 Sexual Assault Reporting Option (SARO) for adult victims**

An adult victim may wish to report to the Police but not give a full statement or formal report because they do not wish to pursue legal action. Police can take this information in the form of the [SARO](#) as an alternative. Victims may complete a questionnaire on the NSW Police website, either providing their contact details or anonymously, with information about the sexual assault to assist NSW Police in developing strategies for targeting offenders and to protect the community.

If the victim elects to take this course of action they need to be aware that a SARO questionnaire is not the same as making a formal report and will not initiate a criminal investigation. Police may, however, contact the victim in the future and request further action in certain circumstances, such as if it appears sexual assaults were committed by a serial offender.

Adult victims will be made aware that they can decide whether or not to participate in any investigation, regardless of whether or not a report has been made. A decision to involve Police at the early stages will help ensure that all relevant crime scene evidence is collected, any forensic evidence collected can be analysed, and witness statements can be taken when they are fresh in the memories of the people involved.

### **4.3 Reporting allegations of sexual assault by a NSW Health worker**

In making and responding to a report of an allegation of sexual assault by a NSW Health worker, NSW Health workers will adhere to NSW Health's policies with particular attention to:

- [\*Child Related Allegations, Charges and Convictions against NSW Health Staff\*](#)
- [\*Child Wellbeing and Child Protection Policies and Procedures for NSW Health\*](#)
- [\*Managing Complaints and Concerns about Clinicians\*](#).
- [\*Managing Misconduct\*](#)

Under the [\*NSW Health Code of Conduct\*](#) and NSW Health policies on managing misconduct, NSW Health workers must, upon becoming aware, report to the relevant NSW Health employer (usually via the relevant Workforce Director or equivalent):

- any criminal charge or conviction for an offence of a sexual nature against another NSW Health staff member
- any allegation, charge or conviction involving an under-18 year old against another NSW Health staff member
- any work-related allegation of a sexual nature against another NSW Health staff member where the alleged victim is over 18 years or older.

The Code of Conduct also requires that staff report any breach or concerns about a breach of the Code to their manager.



#### **4.3.1 Child related allegations, charges and convictions against NSW Health staff**

The NSW Health policy directive [Child Related Allegations, Charges and Convictions against NSW Health Staff](#) outlines the mandatory requirements for managing child-related allegations, charges and convictions against a current NSW Health staff member where the alleged victim was under the age of 18 at the time of the offence (even if the victim is now an adult). This policy directive, alongside [Managing Misconduct](#), provides detailed guidance on risk management, investigating, responding to, and recording child-related allegations, charges and convictions by a NSW Health worker.

Under this policy NSW Health staff are required to notify and report on 'reportable conduct' which includes (but is not limited to) "any sexual offence or sexual misconduct, committed against, with or in the presence of a child [under 18 years] (including a child pornography offence or an offence involving child abuse material)" by a current NSW Health staff member. This obligation extends to non-work related matters.

In addition to any mandatory reporting notification to the Child Protection Helpline/Child Wellbeing Unit/ NSW Police, the relevant NSW Health employer (usually via the relevant Workforce Director or equivalent) must be immediately notified.

The notification to the Workforce Director or equivalent will include enough information for them to be able to assess and manage risks and any relevant employer obligations, e.g.:

- details of the allegation, charge or convictions against the NSW Health worker, including details of the source of the information and the name and age of the child
- action that has been taken (i.e. contact with Child Protection Helpline, NSW Police)
- advice provided to alleged victim or their family, as relevant
- contact details of relevant persons involved in the matter
- any other information that may help the Workforce Director or equivalent meet NSW Health's employer responsibilities in line with the NSW Health policy on child related allegations, charges and convictions.

If a NSW Health worker is required to make a report about alleged sexual assault of a child (under 18 years at the time of offence) by a current NSW Health staff member as per [Child Related Allegations, Charges and Convictions against NSW Health Staff](#), the Health worker will:

- Inform the client of NSW's Health's obligation to notify the matter to the Police and any other relevant agencies.
- Inform the client of their rights to make their own report to the Police.
- Refer the client to a NSW Health SAS (if not already their client). Consideration will be given to whether it is more appropriate to refer to a SAS outside of the district/network depending on where the current NSW Health worker against whom the allegation has been made is employed.
- Consult with the SAS about how to proceed with the matter and provide appropriate support even if the client decides not to take up the SAS referral.

In matters involving allegations of sexual assault against a NSW Health worker, the first responsibility of the SAS is to provide a service to the client. The SAS is required to offer a counselling, medical and forensic response (as appropriate) in relation to the disclosure and support the client through the reporting and any investigation process. The SAS client's counselling notes will not be available to any investigation by the district/network concerning an allegation against an employee except with the appropriate consents.

#### **4.3.2 Allegation of sexual assault of an adult by a NSW Health worker**

Allegations that a NSW Health staff member has sexually assaulted an adult (defined as 18 years or over) must be managed in line with NSW Health policies on managing misconduct.

Where such an allegation is work-related, it must be reported to NSW Police and the relevant NSW Health employer (via the relevant Workforce Director or equivalent). The notification to the Workforce Director or equivalent will include enough information for them to be able to assess and manage risks and any relevant employer obligations in line with the [Managing Misconduct](#) policy.

Work related allegations include, but are not limited to:

- the alleged sexual assault was committed on NSW Health premises, and/or
- the alleged sexual assault was committed in connection with the provision of health services to the alleged victim, either now or in the past, and/or
- the alleged victim is a current or recent Health client/patient of the alleged perpetrator, and/or
- the alleged victim states or indicates that they met or came into contact with the alleged perpetrator through the provision of a health service, and/or

In allegations requiring notification to the relevant NSW Health employer, the SAS worker's role may include:

- providing support, as required, to the victim to make their own complaint to NSW Police
- advising the alleged victim of NSW Health policy requirements regarding work related allegations / charges or convictions against NSW Health staff
- assessing any safety factors that need to be considered in any response by NSW Health (e.g. ongoing contact with alleged perpetrator, address known etc.)
- liaising as appropriate with Workforce regarding any safety issues, contact with alleged victim, victim's intent to make a complaint to NSW Police and/or willingness of victim to be involved in a workplace investigation (if one proceeds) etc.
- keeping the alleged victim informed, as appropriate, of NSW Health action in relation to any workforce action/ investigation process etc.

Non-work related allegations of a sexual assault against NSW Health workers where the alleged victim is 18 years or older are not required to be notified to the relevant NSW Health employer.

If in doubt about whether an allegation is work-related and/or needs notifying to the relevant NSW Health employer for management under NSW Health policies for managing misconduct, SAS

workers will consult their manager. If required, managers may seek further advice from the Ministry's Workplace Relations Branch or the Prevention and Response to Violence, Abuse and Neglect Unit, NSW Ministry of Health.

#### **4.4 Reporting of a sexual assault involving a mental health consumer.**

Consumers of mental health services are entitled to sexual safety and will be supported to access SASs. Where a mental health consumer reports sexual assault, NSW Health staff will follow Section 6, 'Reporting and Recording', in the NSW Health [Sexual Safety of Mental Health Consumer Guidelines](#), with particular attention to reporting requirements to DCJ and Police.

#### **4.5 Reporting allegations of sexual assault by non-NSW Health workers**

Registered health practitioners, their employers and education providers are required to notify the Australian Health Practitioner Regulation Authority (AHPRA) of another health practitioner's notifiable conduct as soon as practicable after forming a reasonable belief. Notifiable conduct includes sexual misconduct in the practice of the profession (e.g. where patients/patient's family members are involved). See [www.ahpra.gov.au](http://www.ahpra.gov.au) for mandatory notification guidelines. The notification can be made by downloading and submitting a form or by phone to the AHPRA office.

NSW Health workers will share relevant information in accordance with Chapter 16A of the [CYPCP Act](#) when they have concerns regarding the safety, welfare or wellbeing of a particular child or young person or 'class of children or young persons' because the alleged perpetrator works for a prescribed body, which includes the NSW Police, a public service agency or a public authority<sup>6</sup> (see also [Section 22.2.2](#)).

NSW Health workers will consult with DCJ and/or NSW Police if appropriate in the circumstances to help determine when and how they will share relevant information with the AHPRA or a prescribed body to ensure that doing so will not interfere with an active investigation.

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<sup>6</sup> Prescribed bodies are defined in section 248 of the [Children and Young Persons \(Care and Protection\) Act 1998](#).

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## **PART TWO: RESPONSIBILITIES OF SPECIFIC NSW HEALTH SERVICES, REFERRAL PATHWAYS AND INTERACTION OF KEY REFERRERS WITH SASS**

A person who has experienced sexual assault may present to the NSW Health system through any type of service. However, the most common initial contact points with NSW Health services for an adult, young person or child needing a response to sexual assault may be through:

- a hospital ED
- a JRU or JCPRP Health worker
- a remote area Sexual Assault Assessment Centre
- a SAS.

A client may contact the service themselves (self-referral) or be referred by another individual or agency, such as NSW Police, JRU or JCPRP, DCJ, other NSW Health agencies or facilities (e.g. mental health facilities), corrections facilities (adult or juvenile), or disability services or carers. Contact may be by telephone or face-to-face or electronic communication.

The following part of the policy and procedures outlines the roles and responsibilities of the most common initial contact points and key referrers in responding to sexual assault (adult and child) and the role and responsibilities of SASs in receiving referrals from, and working in collaboration with, these referral sources. NSW Health agencies other than those listed below should follow the normal referral pathway into SAS outlined in [Section 13.1](#).

## 5 EMERGENCY DEPARTMENTS (EDs)

### 5 Emergency departments (EDs): summary

- EDs have a key role in the assessment and management of injury and care, as a first responder to sexual assault, and as a key part of the referral pathway through to SASs.
- EDs will follow the identified procedures and protocols in responding to sexual assault outlined in the flowcharts ([Section 5.1](#)) and detailed below. There are slightly different requirements for EDs with a SAS on site ([Section 5.2](#)) compared to EDs without a SAS on site ([Section 5.3](#)).
- EDs will follow the specified documentation requirements for sexual assault ([Section 5.4](#)).

Clients may present to a NSW Health hospital in crisis in a variety of circumstances. They may present without notice and could be unaccompanied, or with NSW Police or JCPRP. They may also present via an inter-hospital transfer, by referral, or via ambulance.

How the person arrives and whether the SAS has been contacted in advance of their arrival will partially determine the amount of information available upon which the SAS counsellor will be able to make preliminary decisions about managing the SAS response.

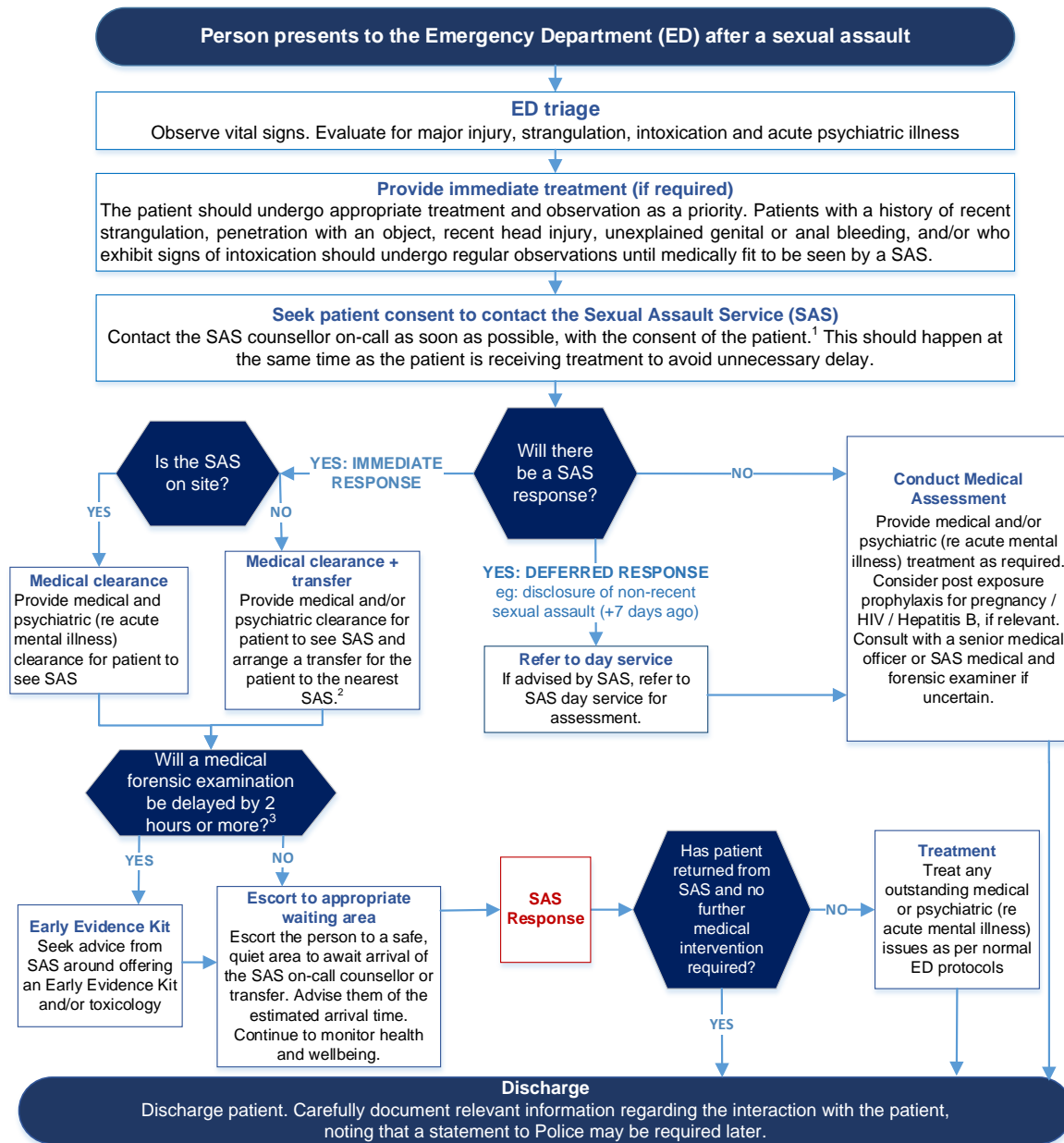
In the case of recent sexual assault (in the last seven days), the ED is likely to have a key role in the assessment and management of injury and care. In many cases, the ED is the first responder from NSW Health to a person who has presented after a sexual assault.

Two separate flowcharts outlining the ED response to sexual assault (one for adults over 16 years and the other for children under 16 years) are provided below, alongside the more detailed guidance contained in the remainder of this section.

## 5.1 ED flowcharts: adult (figure 8) and paediatric (figure 9)

### Management of Sexual Assault in the Emergency Department (Adult)

Sexual Assault Services (SAS) offer crisis responses, crisis counselling, medical care and forensic examinations to victims of sexual assault. All patients who present within 7 days of a sexual assault should be referred to a SAS as a matter of urgency to provide appropriate support and prevent loss of forensic evidence. Patients presenting more than 7 days after the sexual assault should be triaged as required and the SAS counsellor on-call contacted and advised if the client is presenting in crisis.



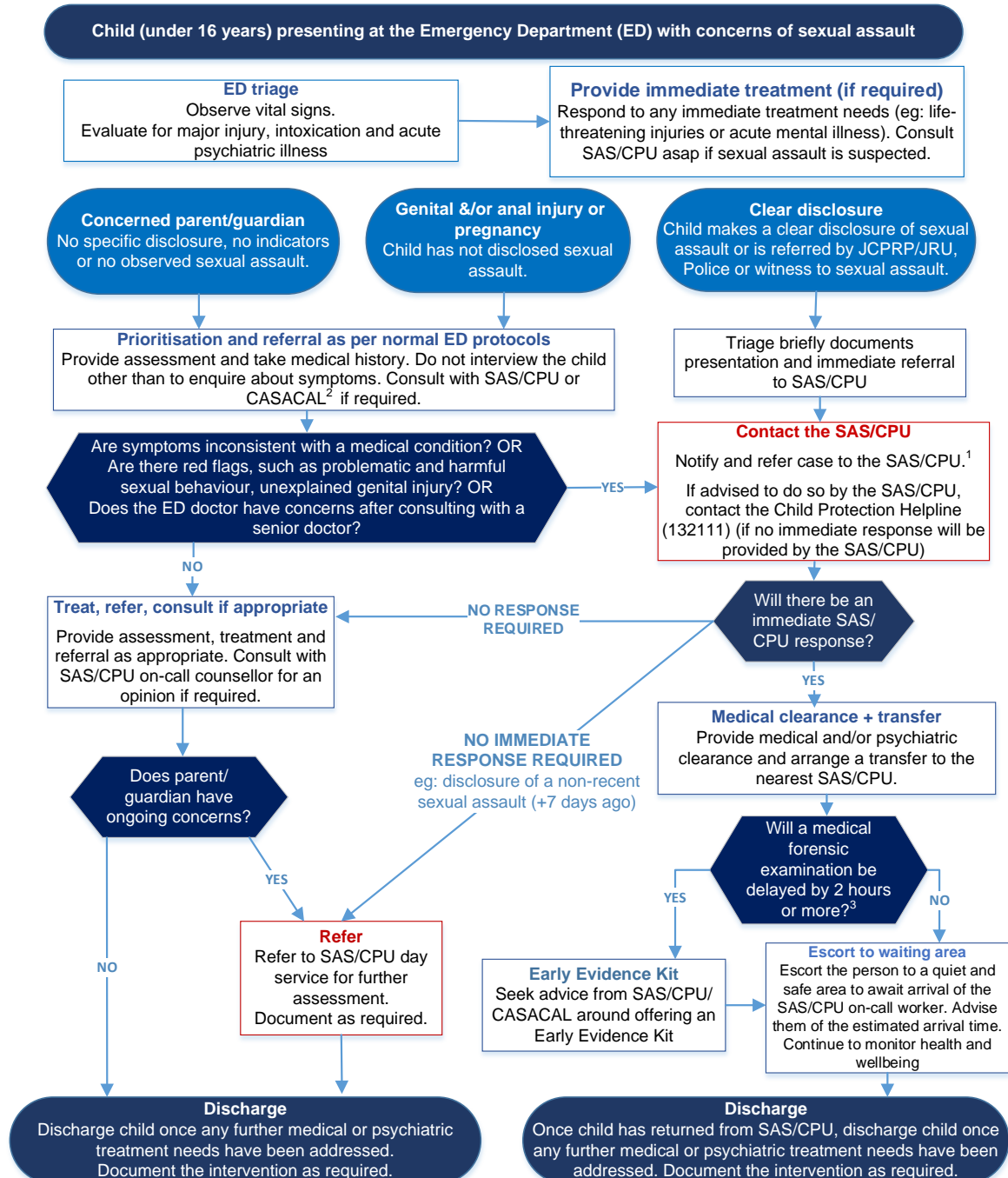
#### Notes

- When contacting the SAS, they will require the following information:
  - Name and DOB of patient.
  - Date, time and type of assault if known (e.g. penile / vaginal / oral / anal).
  - Any issue that might interfere with the patient giving informed consent e.g. <14 years of age, intoxication, intellectual disability, acute mental health concerns, reduced consciousness, physical trauma e.g. pain or bleeding, or need for an interpreter.
  - Contact details for any accompanying or referring police officers.
- SAS must be consulted prior to transfer.
- A medical and forensic examination may be delayed for a range of reasons, including where a medical forensic examiner is unavailable, travel time to the nearest SAS is more than two hours, or if the patient is unable to consent to an examination due to intoxication or acute mental illness.



## Management of Sexual Assault in the Emergency Department (Child)

Sexual Assault Services (SAS) and Child Protection Units (CPU) offer crisis responses, crisis counselling, medical care and forensic examinations to victims of sexual assault. All children and young people who present within 7 days of a sexual assault should be referred to a SAS/CPU as a matter of urgency to provide appropriate support and prevent loss of forensic evidence. Other sexual assault presentations should be triaged and the SAS/CPU counsellor on-call contacted and advised if the patient is presenting in crisis.



### Notes

1. Note any red flags for referral. The SAS/CPU on-call worker will require the following information: name and DOB of patient; date, time and type of assault if known through spontaneous disclosure (e.g. penile / vaginal / oral / anal); any medical information including intoxication, intellectual disability, acute mental health concerns, reduced consciousness, physical trauma, history of recent strangulation/penetration with an object/recent head injury/unexplained genital or anal bleeding; contact details for any accompanying or referring JCPRP/JRU/police officer; and whether a report to the Child Protection Helpline has been made.

2. The Child Abuse and Sexual Assault Clinical Advice Line (CASACAL) (1800 244 531) is a 24/7 medical and forensic advice line on medical and forensic examinations, medical care (and documentation) for children and young people who are suspected victims of sexual assault, physical abuse and neglect. Advice should be sought from CASACAL after using local pathways.

3. A medical and forensic examination may be delayed for a range of reasons, including where a medical forensic examiner is unavailable, travel time to the nearest SAS is more than two hours, or if the patient is unable to consent to an examination due to intoxication or acute mental illness.

## **5.2 Hospitals with a SAS on site**

Hospital EDs with a SAS on site will:

- See victims of sexual assault as quickly as possible.
- Undertake initial triage and provide any required immediate medical care prior to, or at the same time as, contacting the district/network SAS on-call service.
- Ensure ED staff including (but not limited to) nursing, medical, and clerical staff:
  - respond to victims of sexual assault in a manner that is sensitive to confidentiality and the emotional and psychological impact of the sexual assault; and
  - are aware of the intake procedures ED is to follow ([Section 5.1](#)).
- When a victim presents in crisis<sup>7</sup> following a sexual assault, contact the on-call SAS counsellor as soon as appropriate, after immediate medical and/or psychiatric (in the case of acute mental illness) needs have been addressed, to consult on the appropriate time for the SAS counsellor to attend the hospital. In the case of an adult patient, the SAS will only be contacted with the permission of the patient. The SAS counsellor (and medical and forensic examiner in the case of a joint call-out model — [Section 14.2](#)) will attend the hospital within one hour of contact by the ED, unless the ED advises a need to delay — e.g. for treatment of serious injuries or because intoxication is affecting the patient's capacity to consent.
- Where possible and appropriate, make a telephone available to the patient and/or make other reasonable efforts to connect them with the on-call SAS counsellor (noting that they may have had their phone taken by NSW Police or may not have reception in the hospital). This will allow the SAS to provide immediate support and initial assessment of needs for the patient over the phone to assist to streamline the SAS service response.
- Consult with the SAS regarding the need to preserve forensic evidence, particularly if treatment of serious injuries is required and/or there is a delay in the SAS response.
- Once the patient is medically and psychiatrically (in the case of acute mental illness) stable and any urgent needs to preserve forensic evidence have been addressed, escort the patient to a quiet area that maintains safety and privacy to await the on-call SAS counsellor (and medical and forensic examiner in a joint call out model — [Section 14.2](#)), and advise them of estimated arrival time. The ED will monitor the patient for any signs of deterioration in their physical or mental health until the SAS medical and forensic examiner arrives.
- Provide support and information to family members, carers and significant others attending with the patient.
- Provide a safe and private space for the patient to speak with the SAS that is not in the ED waiting room ([Section 23.2.1](#)).
- Patient will only be discharged once the SAS intervention is completed and the ED has confirmed that no other medical or mental health needs require a response from either the ED or another service (e.g. mental health services).

<sup>7</sup> See [Section 14](#) for service criteria for crisis response.

### **5.3 Hospitals without a SAS on site**

Where there is no SAS on site (i.e. there is no SAS in the same health facility/campus as the ED), the ED will:

- Provide an entry point into NSW Health for victims of sexual assault.
- Perform triage and provide required emergency medical care to the patient if required.
- Contact the SAS on-call service and collaborate with it to ensure the needs of the patient are met in accordance with the [NSW Health Guide to the Role Delineation of Clinical Services](#) (Appendix 6).
- Contact the designated on-call SAS counsellor of the most appropriate SAS,<sup>8</sup> who will contact the on-call SAS medical and forensic examiner to determine the appropriate response. The medical and forensic examiner, in consultation with the SAS counsellor and referring facility, will:
  - Determine appropriate timing and nature of the transfer of the patient to the NSW Health facility where the SAS is located. Each ED without a SAS on site will have local procedures for transport of patients to the most appropriate SAS consistent with any relevant statewide NSW Health and interagency policies.<sup>9</sup> EDs are to exercise sensitivity and care when transporting victims; the victim will preferably not be alone and are to be accompanied by a support person of their choice and, if appropriate, a NSW Health worker.
  - Provide advice to the transferring hospital on preservation of forensic evidence and the use of an Early Evidence Kit (EEK) if considered appropriate.<sup>10</sup> This includes taking into account both possible forensic needs and the patient's comfort and wellbeing prior to providing them with food or drink or advice about when they can eat or drink or use the toilet.

### **5.4 Documentation requirements of EDs for sexual assault presentations**

When a person who has been sexually assaulted presents to a NSW Health ED and discloses sexual assault to triage, ED is to document the presentation in the medical record as per below:

- Presenting problem: This will usually be coded as "Assault — alleged," or entered as free text, depending on the source electronic medical record system used.
- Triage note/progress note documentation: Any severe physical injuries and the findings by the triage (blood pressure, temperature, etc.) are to be recorded. Any medical treatment and medication provided to be recorded as per usual policy in the electronic medical record. Minimal notation will be made about the disclosure of the sexual assault and information recorded will focus on what is clinically relevant to the assessment and treatment of injury.

<sup>8</sup> The most appropriate service will be determined in consultation with the client and, if appropriate, the SAS, and will take into account: where the closest SAS is (this may be outside district boundaries); medical or forensic needs (e.g. relevant timeframes); access needs of the client, such as proximity to their home; local procedures, protocols and agreements between SASs; and any other factors.

<sup>9</sup> For example, current interagency policy for adult sexual assault requires NSW Police to transport a victim to the closest SAS, or, if the victim has not initially reported to NSW Police and has presented to a NSW Health service without a SAS, it is the responsibility of that NSW Health service to transport the victim to the nearest SAS.

<sup>10</sup> The Early Evidence Kit Clinical Guideline is currently under development.

For example, 'Patient presented and disclosed sexual assault. Referred to Sexual Assault Service for review following medical clearance'.

- Discharge note documentation: Patient seen by the SAS, discharged.

This information is to be documented in accordance with the NSW Health [Policy Health Care Records Documentation and Management](#). ED staff will keep in mind this documentation may be used for future legal purposes and will take care in recording information in a factual and clear way.

The ED staff will also take necessary steps to prevent information about the sexual assault appearing in a discharge summary and then automatically transferring to My Health Record (unless this is with the informed consent of the patient).

## 6 JOINT CHILD PROTECTION RESPONSE PROGRAM (JCPRP)

### 6 Joint Child Protection Response Program (JCPRP): summary

- NSW Health is part of the tri-agency JCPRP alongside the NSW Police Force (NSW Police) and Department of Communities and Justice (DCJ).
- The over-riding focus of NSW Health interventions in JCPRP is the health, safety and wellbeing of the client. This is achieved primarily through the provision of integrated psychosocial, medical and forensic responses to violence, abuse and neglect, including sexual assault.
- The JCPRP partnership is governed by a range of statewide and local policies, procedures and protocols, which NSW Health staff will adhere to.
- JRU and JCPRP Senior Health Clinicians (SHCs)/Health Clinicians (HCs) and SAS staff will work together and fulfil their respective roles and responsibilities as part of the NSW Health role in the JCPRP response. This includes providing service to children, young people and their families/carers, regardless of whether JCPRP accepts or rejects their matter.
- Where a matter does not proceed with JCPRP for any reason, substantiation by DCJ is not required for a child and their non-offending family/carers to receive services from SASs.

NSW Health is part of the tri-agency Joint Child Protection Response Program (JCPRP) (formerly known as the Joint Investigation Response Team [JIRT]), alongside NSW Police and DCJ. The program provides a comprehensive and coordinated safety, criminal justice and health response to children and young people alleged to have been subjected to sexual abuse, serious physical abuse or extreme neglect that may constitute a criminal offence. NSW Health has primary responsibility to respond to the physical and psychological outcomes of violence, abuse and neglect.

NSW Health provides integrated psychosocial, medical and forensic responses for children, young people, their families and carers. The key focus and over-riding principle of any NSW Health involvement and intervention is the health, safety and wellbeing of the client. Alongside our medical response, Health provides forensic examinations to help prevent re-traumatisation of the child or young person and to support our interagency partners in their criminal justice and child protection roles.

All potential JCPRP reports go from the Child Protection Helpline to the Joint Referral Unit (JRU). The JRU provides a centralised (triaged) decision-making process for accepting and investigating JCPRP referrals based on joint information gathering and analysis by all three agencies. The JRU determines whether a referral is accepted for a JCPRP response and, if not accepted, whether a DCJ Community Services Centre (CSC) and/or a Police Area Command (PAC) (metropolitan)/ Police District (PD) (rural) will lead a local response.

When a matter is accepted for a JCPRP response, the JRU Health Team will communicate with the relevant JCPRP Health unit and also action urgent referrals, including to a SAS, as required. When a matter is not accepted for a JCPRP response, the JRU will aim to identify from the initial

report the child or young person's health needs and initiate an appropriate health referral pathway, including to a SAS. The local health response, including the timing of Health contacting the child/young person and/or their family, can then be coordinated with the DCJ CSC or NSW Police PAC/PD statutory response. Each report is sent from the JRU with a response priority timeframe to guide JCPRP as well as local police and DCJ decisions about the timing of the field response. The prioritising of any SAS response needs to be in line with the requirements of this policy.

After JRU operating hours, the Child Protection Helpline (or NSW Police) manages the JCPRP response and liaises directly with NSW Health on-call SAS; VAN services; or hospital social work and medical staff, as required.

As children presenting solely with PHSB are below the age of criminal responsibility and therefore don't meet the criteria of a tri-agency response that involves a criminal investigation, the information below focuses on referrals related to sexual assault.

## **6.1 Health's role in JCPRP**

NSW Health has the following four key roles in the JCPRP partnership:

- sourcing and sharing relevant Health information about the child/young person to assist decision-making and/or to support JCPRP Local Planning and Response
- a liaison role between Health and other agencies (i.e. NSW Police and DCJ) to support criminal investigations and safety assessments
- coordination and planning with NSW Health services to facilitate timely access for children/young people and their families
- direct interaction and interventions with the children/young people and their families to assess clinical need and support health service engagement from the point of crisis onwards.

## **6.2 Involvement of a JCPRP Senior Health Clinician / Health Clinician**

Where a JCPRP senior health clinician (SHC)/health clinician (HC) has been involved with and is referring a child or young person to a SAS, the SAS counsellor will:

- document the referral information provided, including whether a JCPRP investigative interview has occurred prior to the presentation at the SAS, and
- collaborate with the JCPRP SHC/HC and provide information to inform the JCPRP's local decision-making. This may include the sexual assault worker being invited to attend the JCPRP local planning and response meeting.

The JCPRP SHC/HC will:

- provide information to the SAS counsellor regarding JCPRP decisions
- communicate any disclosures made by a child or young person during the JCPRP interview to the medical and forensic examiner prior to their examination, and
- in some circumstances, especially in rural areas with limited SAS coverage, attend the medical and forensic examination to support and co-ordinate the process, if the family consents and it has been discussed and negotiated with the SAS as being in the best interests of the child.



### **6.3 Local protocols and procedures**

Each district/network has a locally developed JCPRP Health program model that includes local processes and procedures to ensure that there is no delay to the NSW Health response on urgent referrals. SAS will develop local protocols and procedures in each district/network that are consistent with JCPRP Local Planning and Responses Procedures and any local arrangements that have been put in place to ensure efficient JCPRP/JRU referral processes.

### **6.4 Role of JCPRP SHCs/HCs in responding to sexual assault**

The JCPRP SHC/HC will:

- facilitate access to appropriate NSW Health services for JCPRP accepted matters and progress JRU referrals by coordinating, consulting and liaising with relevant services to facilitate a NSW Health response
- facilitate timely and effective access to medical and other health services for JCPRP accepted matters, in consultation with SASs or other relevant services
- conduct health assessments for children and young people in discussion with an appropriate medical officer employed by the district/network. This includes review and analysis of relevant health background information as well as information shared by JCPRP partner agencies.
- where possible, and within their work load capacity, provide crisis counselling to non-offending parents/carers and build rapport with children, young people and families to enhance access to other NSW Health services.

The above functions allow the JCPRP SHC/HC to make clinical decisions about the health needs of children and young people and progress JRU referrals by co-ordinating, consulting and liaising with relevant services to facilitate a Health response.

Early NSW Health intervention in the JCPRP process can help mitigate the negative impacts of abuse that may prevent the child actively participating in the investigation and criminal justice processes. Early NSW Health support to non-offending family members and carers can also enhance their capacity to ensure the physical and psychological safety of the child and help to prevent denial or minimisation of abuse that can sometimes occur after disclosure.

### **6.5 Process to respond to a JCPRP/JRU referral**

- Where a child or young person is accepted for a JCPRP response, information about the matter is provided via ChildStory. In addition, the JRU Health Team may provide additional information about a matter accepted or rejected by the JRU via the local JCPRP Health Program Contact Point. The decision as to what information is shared, and when, is based on the need for the JCPRP SHC/HC and local health services to understand, respond to, and plan for the child or young person's safety, welfare or wellbeing without undue delay. This assessment will be done in conjunction with DCJ and NSW Police.
- The JRU Health Team will summarise information shared by all agencies during the JRU assessment process on the *Provision of information by the JRU to a health service for action* form.
- For urgent referrals:

- the JRU Health Team will attempt to contact the Contact Point to alert them to urgent matters and to check that they will be actioned accordingly
- if the Contact Point cannot be reached, urgent referrals will likely to go to a Child Protection Unit, SAS or hospital-based service for cases of reported sexual assault or serious physical abuse and neglect. This is to provide timely medical services, forensic evidence collection, and/or psychosocial assessments, as required, to meet the child or young person's immediate needs.
- Urgent information may need to be provided to a NSW Health worker seeing the child or young person before the JCPRP response is initiated, so that immediate support can be provided without the JCPRP investigation being compromised.
- Where there is concern that urgent medical care is required, transport to an ED for assistance and care must not be delayed.
- In cases where the JCPRP SHC/HC is unable to respond to an urgent contact from the JRU for a SAS service, the JRU Health Team will facilitate a direct referral to a SAS. This will be an agreement between the JCPRP SHC/HC (if available/contactable) and the JRU manager or SHC.
- Where an urgent after-hours response to a report is required, the Child Protection Helpline or NSW Police will manage the response and liaise with the SAS as required.
- Occasionally the JRU Health Team will initiate an urgent after-hours health response direct to an ED or SAS when needed at the end of the business day and where the JCPRP SHC/HC is unavailable.

## **6.6 Role of SASs in the JCPRP investigations of sexual assault**

The role of SASs varies throughout the JCPRP investigation. As soon as a referral is received from the JRU or JCPRP the SAS will contact the referrer and commence planning for how the SAS will engage with the non-offending parent/carer and child/young person. This is to occur in line with the JCPRP local planned response, and, in particular, the planning and timing of any police interview (as contact cannot be made with a child under 14 years old) prior to the JCPRP interview. Where the JCPRP Health service cannot make contact with the non-offending parent or carer prior to or during the investigative interview, the SAS will, after consultation with JCPRP Health and the JCPRP partner agencies, and as part of the agreed JCPRP local response:

- Make telephone contact with the non-offending parent/carer of a child/young person being interviewed by JCPRP within 24 hours from the first business day after receiving their details. This will ensure a prompt response is offered to families. The purpose of the phone call is to engage families and provide crisis counselling, information and support.
- Meet the immediate needs of the child or young person over 14 years and the non-offending parent/carer by providing trauma-informed counselling, advocacy, support, and information.
- Attend the JCPRP unit or place of interview, if the child/young person is already known to the SAS and has requested the SAS counsellor's support, or if JCPRP staff have requested the SAS to meet with the child/young person and their non-offending family/carer after the investigative interview to discuss the role of the SAS.

- Offer counselling, advocacy, support and information for children under the age of 14 years once the JCPRP interview has been attempted or completed and/or following disclosure during a JCPRP interview.
- Make available written material to the local JCPRP about the SAS, which includes relevant contact details.
- Provide follow-up counselling to the child or young person and non-offending family/carers to address the impact of disclosure and the short and long-term effects of the sexual assault.
- Provide ongoing support, court preparation and court support to the child/young person and their non-offending family/carers where required.

## **6.7 Children who do not continue with the JCPRP process**

Substantiation in the context of child protection refers to where a decision is made, following investigation, that a child or young person is 'at risk of significant harm' as set out in section 23 of the [CYPCP Act](#). Substantiation by DCJ is **not** required for a child and their non-offending family/carers to receive services from SASs.

In some cases, a matter may be rejected by JRU or is not eligible for a JCPRP response, because no criminal investigation is required (e.g. where a child under 10 has engaged in sexually harmful behaviours against another child or where NSW Police have assessed that no further criminal justice response is required). In other cases, a child who has been sexually abused may not disclose during the JCPRP investigative interview, the child may refuse or be unable to participate in the interview process, or the case may not proceed with JCPRP for another reason. Further, substantiation doesn't always occur immediately after interview and so may not be known at the time of referral to a SAS. In such cases, children, young people and their non-offending family/carers may still receive a response from SASs.

As noted above, the NSW Health role is to focus is on the ongoing safety, health and wellbeing of the client. Clinical need based on a clinical assessment, rather than substantiation or confirmation of abuse, is therefore the key criteria for referral and entry to a SAS. To receive and accept a referral for a child, the referrer (usually the JCPRP SHC/HC) or the SAS only needs to believe that the child may be in need of a service response from the SAS.

Where a child has not made a disclosure during the JCPRP interview, the child has not been interviewed, or the JCPRP process is not proceeding, and there are indicators of sexual assault (including disclosure other than during the interview process), the JCPRP SHC/HC may identify that a SAS referral is indicated through the following steps:

- The JCPRP SHC/HC will discuss the matter and the child or young person's needs with JCPRP Police and DCJ colleagues during the local planning and response (LPR) process. Based on the information obtained during the LPR and the preliminary investigative processes, as well as information obtained from contact with the child and family, the JCPRP SHC/HC will assess whether to refer to a SAS.
- Information informing this clinical assessment by the JCPRP SHC/HC may include, but is not limited to:
  - the age of the child

- disclosure to another person (e.g. parent, teacher or other trusted adult)
  - the child presenting with active trauma symptoms (e.g. emotional distress, unexplained changes in functioning or behaviours, intrusive cognitions, nightmares, hyper-vigilance, poor appetite, depression, anxiety)
  - previous disclosure by another child regarding a perpetrator who has had contact with the child
  - there is knowledge of grooming behaviours by the person of interest involving the child
  - a credible witness to the abuse (e.g. a parent)
  - physical indicators (e.g. pregnancy or sexually transmitted infections)
  - sexually problematic behaviours for children and young people of any age
  - a request for support from a SAS from the family/carers of the child
  - current Family Court proceedings.
- The JCPRP SHC/HC will then contact the manager of the relevant SAS or their delegate (e.g. the intake worker) to discuss the referral in detail. The purpose of this discussion is to review and document the factors that indicate that the child or young person (and/or non-offending family members or carers) is in need of a specialist SAS response. Relevant and appropriate information gathered during the LPR and the preliminary investigative processes will be reviewed, along with the information gathered through the clinician's interaction with and assessment of the child and family. This meeting will also document how safety issues are being managed.
  - In complex cases, a face-to-face meeting may be convened by the JCPRP SHC/HC and SAS manager. Other NSW Health clinicians (e.g. a SAS medical and forensic examiner or mental health service) may be consulted or included in this meeting to inform the decision-making as appropriate in the circumstances. Where required, a JCPRP DCJ, JCPRP Police or DCJ staff member may attend the meeting. In some cases, while it may be determined that sexual assault counselling is not indicated for the child at this stage, a decision may be taken to offer counselling to the non-offending family or carers of the child and to support the family with appropriate supportive responses to the child and with management of the safety issues and the uncertainty of the situation.

DCJ may also separately initiate referrals to SASs in these circumstances where a JCPRP response is not proceeding (see [Section 7](#)).

Following a referral of this type, the key focus of the SAS will be to respond to the health, safety and wellbeing concerns of the child or young person and their parents or carers. Safety assessments in this context (see also [Section 13.5.1](#)) will involve short-term information gathering and reflecting on what may be the most appropriate response by all involved, including family members and relevant agencies. It must be clearly established by the SAS that this process is only limited to short-term work (up to 3-4 sessions) to ensure that there will not be a flow-on to ongoing counselling approaches, which may be of little use and could also be detrimental.

A short report to follow this safety assessment will be written and distributed by the SAS to both the family and involved services and include:

- a statement of the issues of concern

- how the assessment was conducted, including the number of meetings with the parent/s and child, and the method of information gathering
- recommendations for the child and family
- referral pathways or ongoing safety plans
- the activities (e.g. advocacy, participation in case planning) the SAS can contribute to help establish or re-establish safety.

In instances where it is assessed that there is too high a level of risk (physical, emotional or psychological) to the child or young person for counselling to occur, it will remain the responsibility of the parents/carers and all services involved with the child or young person (which could include CPCS, DCJ and SAS) to work together to discuss, plan and implement an appropriate safety framework for the child or young person.

It is never be the responsibility of a child or young person to keep themselves safe. Options such as protective behaviours education or developing personal safety plans will not only be rendered useless in the face of ongoing threats or actual harm, they may inadvertently increase risk levels. SAS counsellors will hold firm positions about not entering into these aspects of an ongoing safety plan and instead place responsibility on to the adults involved in the ongoing care of the child, using whatever resources are available or may be made available.

## 7 DEPARTMENT OF COMMUNITIES AND JUSTICE (DCJ)

### 7 Department of Communities and Justice (DCJ): summary

- DCJ is a key referrer into SASs for child sexual assault, particularly where a matter is rejected by JCPRP or is not proceeding for any reasons.
- DCJ may refer to a SAS in these circumstances following a risk and safety assessment that takes into account relevant information about whether or not a SAS response may be indicated.
- The SAS will work with DCJ in providing a service response to a child and their family/carers referred by DCJ.

DCJ may, following a safety and risk assessment, believe that a referral to a SAS is appropriate for the child, young person and/or their non-offending family and carers where:

- the child has not disclosed during the JCPRP interview or is not interviewed, or
- a JCPRP response is not required or is not progressing for whatever reason (including where JCPRP reflects and refers to DCJ for further assessment), and
- there are strong indicators of sexual assault present.

Information informing DCJ's assessment about whether to refer to a SAS may include but is not limited to:

- disclosure to another person (e.g. parent, teacher or other trusted adult)
- the child presenting with active trauma symptoms (e.g. emotional distress, unexplained changes in functioning/behaviours, intrusive cognitions, nightmares, hyper-vigilance, poor appetite, depression, anxiety)
- previous disclosure by another child regarding a perpetrator who has had contact with the child
- there is knowledge of grooming behaviours by the person of interest involving the child
- there is a credible witness to abuse (e.g. a parent)
- physical indicators (e.g. pregnancy or sexually transmitted infections)
- sexually problematic behaviours for children and young people of any age, and/or
- a request for support from a SAS from the family/carers of the child.

Following a DCJ referral, a case planning process between SAS and DCJ will occur to review what protective action has occurred and what needs to be addressed by each agency to ensure appropriate levels of safety are in place and that a coordinated and integrated approach is taken. The SAS will share information with DCJ in accordance with the requirements of Chapter 16A of the [CYPCP Act](#) (see [Section 22.2.2](#)).



## 8 NSW POLICE FORCE (NSW POLICE)

### 8 NSW Police Force (NSW Police): summary

- NSW Police are an important referrer into SAS, particularly in cases of adult sexual assault or for adult survivors of child sexual assault.
- For an adult victim (16 years and over) of sexual assault referred by NSW Police, a brief initial interview will occur, where possible, and with the victim's consent, between the victim, SAS staff and NSW Police. The subsequent counselling interview will usually only take place with SAS staff.
- The SAS will support an adult victim of sexual assault in reporting to NSW Police if they wish to (note that children require mandatory reporting as per [Section 4.1](#)).

NSW Police are required to advise an adult victim of sexual assault of services provided by SASs and arrange transport to the SAS. For children, this function may be performed by a JCPRP SHC/HC or NSW Police depending on availability.

Where an adult victim (16 years and over)<sup>11</sup> attends the SAS accompanied by NSW Police, a brief initial interview (or handover), will, where possible and with the victim's consent, occur jointly between the victim, the counsellor, the medical and forensic examiner (if the SAS has a joint call out model) and NSW Police. The aim of this brief initial interview is to provide the victim with information about the roles of the counsellor and NSW Police and the options available to the victim, including counselling and medical care. Where the victim is a child, some or all of this brief interview may be more appropriate to conduct with the parent/carer without the child involved, depending on the age and ability of the child.

If the victim chooses to receive a response from the SAS, the subsequent assessment or counselling interview would not ordinarily take place in the presence of NSW Police, unless the victim chooses to have a NSW Police officer present as a support person.

Where an adult victim of recent sexual assault has presented to a SAS unaccompanied by NSW Police, the SAS counsellor will ascertain whether the victim wishes to report the offence, and, if so, will contact the duty officer at the nearest police station ([Section 4.2.5](#)).

For child victims (under 16 years old) who present to a SAS without being referred by JCPRP, and where there is an urgent need to collect physical evidence and JCPRP is not available, the SAS may directly contact NSW Police to report a sexual assault against the child. It will also contact the [Child Protection Helpline](#) (see Sections [4.1](#) and [4.2.2](#)).

SASs develop agreed local referral pathways and relationships with NSW Police in their district. These relationships could be developed through local joint training ([Section 19](#)) and/or community engagement, education and prevention activities ([Section 20](#)).

<sup>11</sup> 'Adult' refers here to a policy definition (rather than a legal definition) where the term 'adult sexual assault' is used for people 16 years and older based on the age of consent to sexual intercourse being 16 years old.

## 9 MENTAL HEALTH SERVICES

### 9 Mental health services: summary

- NSW Health staff will take into account the specific barriers and needs that people with mental health concerns or illness may have in responding to sexual assault.
- Referrals from NSW Health mental health services to SAS will be made in accordance with the [Sexual Safety of Mental Health Consumer Guidelines](#), which includes specific protocols to guide referral ([Section 9.1](#)).
- Where a SAS needs to refer to an appropriate mental health service (e.g. in the case of acute mental ill health), the nature of SAS interventions may need to change from a therapeutic one to advocacy, casework and/or assessment.

Many people who have experienced sexual assault will have historical and/or current mental health concerns or illness. Frequently, these mental health concerns are precursors to, or the consequence of, previous experiences of trauma and adversity, such as physical or sexual assault or childhood experiences of abuse and neglect (Bromfield, Lamont, Parker, & Horsfall, 2010). Experiencing mental illness often coincides with other complex issues, such as historical trauma, substance use and dependence, and, where children are involved, engagement with the child protection system. It is also particularly important to assess and understand both risk and protective variables when working with people who have mental health concerns (Huntsman, 2008).

Barriers that those experiencing mental illness or mental health concerns may face when disclosing sexual assault or attempting to access services include:

- past experiences of breaches of sexual safety, including sexual assault or harassment when accessing mental health services, including sexual assault in inpatient units (Mental Health Complaints Commissioner, 2018)
- fear of health staff and institutions as a response to these past experiences and low rates of accessing mental health services (Ullman, 2007)
- limited capacity to access services for women with serious mental illness due to their being significantly more likely to report adverse psychological effects and to attempt suicide following sexual assault (Latalova, Kamaradova & Prasko, 2014).

### 9.1 Referral from a mental health service

Where a referral to a SAS is initiated by a mental health service (inclusive of medium secure units), the referral process will follow the NSW Health [Sexual Safety of Mental Health Consumer Guidelines](#). These guidelines require that:

- Practical information, advice and strategies are provided to help mental health services to maintain the sexual safety of mental health consumers.
- Disclosures from mental health consumers about incidents that compromise or breach their sexual safety are taken seriously and addressed promptly and empathetically, regardless of the identity or affiliation of the alleged perpetrator, and with the utmost regard for the

complainant's privacy and dignity, past trauma, cultural background, gender, religion, sexual identity, age and the nature of their illness.

- Specific processes are followed in response to a sexual safety incident, including a sexual assault (see Section 5 of the [Sexual Safety of Mental Health Consumer Guidelines](#), 'Responding to a Sexual Safety Incident').
- The appropriate consent has been obtained for the referral to the SAS.
- Clients are provided with support by the mental health service to attend the SAS.
- In referring a mental health consumer to the SAS, mental health staff will inform the on-call counsellor about the consumer's capacity to consent, any guardianship arrangements that are in place, whether an interpreter or other support services are required, and whether the consumer has any injuries or medical issues that require immediate treatment. Staff are to be guided by the wishes of the consumer who has disclosed the sexual assault, where possible.

In cases where a mental health consumer who has experienced sexual assault chooses not to receive a service from the SAS, the SAS may act as consultants to the mental health service (either with the appropriate consents or by the mental health service providing non-identifying information) to help determine an appropriate course of action ([Section 19](#)).

## **9.2 Referral to a mental health service**

An integral role of SASs is to provide responses to the needs of the client while also working alongside mental health services to provide holistic support to the client. Where a victim becomes acutely mentally unwell, or symptoms and associated behaviours create a significant ongoing risk to the safety and wellbeing of adult victims, immediate consultation with and referral to a mental health service must be prioritised. Although therapeutic interventions by the SAS may be put on hold at this time, SAS continue providing advocacy, casework, and/or assessment roles, as appropriate, until acute symptoms subside and the client is ready to reengage with counselling.

Maintaining close liaison with both the client and mental health services is important to ensure that, when it is assessed that the acute safety concerns have subsided, the client is able to return to counselling as soon as is possible. Such alternate roles provided by the SAS can include:

- advice, support and consultation to assist in ongoing joint care planning with, and on behalf of, the client
- information, education and training, so that mental health allied health workers can better identify and respond to adults with combined sexual assault, mental health and/or drug and alcohol problems
- seeking and opening referral pathways for clients whose varied needs are currently not being met by existing services.

## 10 RESTRICTED SETTINGS (CORRECTIONAL OR SECURE INPATIENT FACILITIES)

### 10 Restricted settings: summary

- SAS will provide clients referred from restricted settings with a crisis response for a recent sexual assault (one that has occurred in the past seven days). Both SAS and Justice Health and Forensic Mental Health Network (JH&FMHN) services will adhere to the procedures outlined in [Section 10.1](#) for the provision of a crisis response for recent sexual assault in these contexts.
- SAS may provide follow-up and ongoing therapeutic interventions to clients in restricted settings determined by the patient's need and the resources available at the SAS. These interventions will be guided by the identified practice considerations for working with this population group.

SASs may receive referrals from clients in restricted settings such as correctional centres (for adults), juvenile justice centres (for young people), or high secure inpatient facilities (e.g. the Forensic Hospital or Long Bay Hospital) to address their experiences of sexual assault victimisation. SASs will support clients from these services who have experienced sexual assault, noting, however, that if receiving a referral about an adult sexual assault perpetrator, the work of the SAS must be focused on their experiences of victimisation only and not their perpetration of sexual assault.

### 10.1 Crisis response for a recent sexual assault in restricted settings

Where a referral to a SAS for a recent sexual assault (one in the past seven days) is initiated from within a correctional centre, juvenile justice centre or the Forensic Hospital and Long Bay Hospital the following applies:

- Management of the response to patients who allege sexual assault in (adult and juvenile) custodial settings will follow the Justice Health and Forensic Mental Health Network (JH&FMHN) [Safe Practice & Environment Policy Manual](#) with particular attention to Policy no. 5.140, 'Sexual Assault Management and the accompanying Procedure for Sexual Assault Management'.
- NSW JH&FMHN staff will:
  - Conduct a brief health assessment and inform the person of their right to receive a SAS crisis response (psychosocial and medical and forensic).
  - Contact the SAS if the person wishes to attend and seek advice about when they can attend. Where possible, the victim is not to be transferred to a SAS without discussion with the SAS counsellor (who, in turn, will discuss with the medical and forensic examiner) unless there is an urgent medical need for transfer to an ED, in which case the on-call SAS counsellor will be contacted as soon as possible.
  - Liaise with Corrective Services NSW (CSNSW) or Juvenile Justice (JJNSW) as appropriate to arrange for transport for the victim to the ED where the SAS is, or organise transport in accordance with relevant policy and procedures at the Forensic Hospital and Long Bay Hospital. This transfer is not to be delayed by the SAS if

possible, especially if a delay will result in the need for on-call staff to attend (as opposed to day staff in normal business hours). The person will need to be triaged by ED and medically and psychiatrically cleared to be seen by the SAS.

- Inform the SAS if specific safety precautions are necessary.
- Inform the SAS if the patient has a psychiatric or medical condition or specific consent issues related to age or capacity (e.g. relevant guardianship arrangements) that need to be considered during assessment and/or may impact on the patient's capacity to consent.
- The district/network will carry out a risk assessment to ensure safety for staff, property and other clients of the service in line with [Protecting People and Property — NSW Health Policy and Standards for Security Risk Management](#) in NSW Health Agencies, with particular attention to Chapter 6, 'Security arrangements for patients in custody'.
- Corrective Services or Juvenile Justice Officers will be 'auditory chaperones' only during a medical or medical and forensic examination (see [Section 15.8.11](#)).
- Where the victim in a correctional, juvenile justice or secure inpatient setting does not wish to attend a SAS, JH&FMHN staff may negotiate SAS telephone counselling or inreach.
- Where a victim in a restricted setting is unable to attend a SAS due to issues relating to capacity, mental state or risk to the community, an inreach crisis response will be explored with the on-call SAS counsellor and medical and forensic examiner. The viability for this service must be discussed with the person's treating psychiatrist or delegate (if unavailable) prior. If it is not possible for the SAS to provide inreach or a medical response without a forensic examination, the psychosocial components of the crisis response may be provided over the phone and the SAS medical and forensic examiner may provide advice to medical staff in the restricted setting about appropriate sexual assault medical care and follow-up.

## **10.2 Follow-up and ongoing therapeutic interventions in restricted settings**

Each district/network has a different capacity to provide sexual assault services, both to the community and to JH&FMHN. Apart from a crisis response, which will be provided by the SAS, ongoing services will be determined by the patient's need and the resources available at the SAS. Some SASs have developed individual formal or informal arrangements with JH&FMHN. JH&FMHN and SAS staff will ensure they are familiar with local arrangements.

When providing services in a correctional, juvenile justice or secure inpatient setting, the SAS will consult with JH&FMHN and/or other agencies providing psychosocial and medical services within that facility to provide them with relevant contextual information and help them to determine whether joint work with a particular client is appropriate between that agency and the SAS.

Referrals for adults or young people who are in custody in correctional centres or juvenile justice settings or in secure inpatient settings for counselling for sexual assault that has occurred in the past, or in childhood, will be assessed on the basis of clinical need, availability of other referral pathways, ability of the client to attend the SAS or for the SAS to provide inreach or telephone counselling, and service capacity.



SAS staff providing a service in restricted settings may have either practice or ethical considerations in providing support to individuals who have committed offences. SAS staff will need to consider:

- Prisoner health as a public health issue: individuals in restricted settings come from the community and return to the community following their period of incarceration. It is in the best interests of society that these individuals have access to all healthcare options available in the community.
- The application of a dual lens: considering some individuals as both offenders and victims of violence, abuse and neglect. This duality is considered without detracting from perpetrator accountability and offers an opportunity to consider how responding to victimisation experiences may contribute to more positive future health, social and criminal justice system outcomes.
- That risk and recovery are not mutually exclusive: effective practice with victims who have also offended requires the clinician to engage and manage these domains concurrently to maximise safety and wellbeing outcomes.
- Complex co-morbidities such as mental health issues, disability and substance use that may impact the victim's behaviour, such as affective instability, emotion dysregulation and communication difficulties. SAS counsellors may need to liaise with correctional facility mental health staff to ascertain clinical considerations.
- Histories of complex, untreated victimisation that may lead to challenges in establishing a trusting, safe rapport with professionals.
- Barriers for inmates seeking support, including the normalising of sexual assault within the prison culture, by both prisoners and staff, or staff not believing a report of sexual assault.

In a practice sense, incarceration also presents with therapeutically counterintuitive challenges, such as trauma triggers within the physical and sensory environment and the inherently authoritative operative structure (Miller & Najavits, 2012). However for some individuals, confinement to restricted settings can allow for a degree of relative stability, safety and the opportunity for healthcare access. The 2016 *Justice Health and Forensic Mental Health Network Patients' Experiences and Perceptions Study* found that:

participants reported that breaks from their chaotic lifestyles on the outside, and having access to health care on the inside made them feel more committed to taking care of their health needs. (Justice Health and Forensic Mental Health Network, 2019 at p. 39).

A sense of safety and stabilisation can be supported by SAS counsellors on a relational level. SAS counsellors are to take the same collaborative, respectful, non-judgemental approach to individuals in restricted settings as they would individuals in the community. A SAS counsellor may become aware of issues relating to the risk of harm an individual poses, either to themselves or another person. When a SAS counsellor becomes aware of this information, they will need to report it to the Justice Health and Forensic Mental Health Network Nurse Unit Manager (NUM) of the facility for appropriate follow up.



## 11 PEOPLE WITH DISABILITY, DISABILITY SERVICES AND CARERS

### 11 People with disability, disability services and carers: summary

- The response of NSW Health staff to people with disability who have experienced sexual assault will be informed by understandings of their unique needs and experiences, including common risks and barriers, as well as the communication and support needs specific to the person with disability.
- Additional information to that usually collected at intake may be needed to prepare an appropriate SAS response for a person with disability.
- In providing psychosocial responses to people with disability, SAS will take into account identified therapeutic principles specific to this context.
- People with disability may be in particular need of support, advocacy and casework from a SAS related to their experiences of sexual assault.

People living with disability are subjected to sexual assault at disproportionately higher rates compared to the general community (Murray & Powell, 2008; Mitra-Kahn, Newbigin & Hardefeldt, 2016). In particular, people with an intellectual disability, cognitive and communication and/or sensory impairments, high support needs or behaviours of concern are especially vulnerable and more likely to experience abuse, including sexual assault, than the general population (Barr, 2012). For example, 90 per cent of Australian women with an intellectual disability have been subjected to sexual abuse, with more than two-thirds (68%) having been sexually abused before they turn 18 years of age (Australian Law Reform Commission, 2010). In addition, people with disability face significant barriers to accessing support services.

Responses to people with disability often necessitate collaboration and integration to be effective. The Royal Commission into Institutional Responses to Child Sexual Abuse (2017) found that disability-specific services often lack the skills and knowledge to respond to people who have been sexually abused. It also found that sexual assault and counselling services lack the skills and knowledge to meet the needs of people with disability. There are indications that people with disability fall in between 'disciplinary gaps', where clinicians are either disability or sexual assault specialists but may not have the required knowledge to meet intersecting needs. This can lead to people with disability being caught in a cycle of successive referrals without receiving support, with the eventual result that some victims no longer seek help from services. Collaborative practice and integrated service delivery, including taking into account the information provided below, have potential in breaking down a siloed service system.

### 11.1 Risks and barriers for people with disability

People living with a disability are not a homogenous group and each person's individual circumstances and (dis)abilities are to be considered when providing an effective response. There are some common risks and barriers for people with disability that will be taken into account in the responses provided by SASs.

Risk factors that contribute to this higher rate of abuse include (NSW Ombudsman, 2016):

- living in shared residential care or institutional settings

- the need for intimate personal care provided by others
- abuse being normalised as part of the provision of this intimate personal care
- exposure to multiple carers in supported accommodation settings
- limited ability to understand and/or communicate their experiences of sexual assault
- a reliance and dependence by the person with a disability on staff/carers to support them in their day-to-day care and so a reluctance to complain
- social isolation and a reliance on others for transport
- specific targeting by those who engage in sexual offending because the person with a disability is unable to resist or make a formal complaint.

People living with a disability face additional barriers when disclosing their sexual assault and receiving an effective response, including:

- disbelief that sexual assault occurs or a dismissal of a disclosure as unreliable
- assumptions that if sexual assault has occurred, it does not matter, as the victim may not remember or understand what has happened to them
- a perception that if someone cannot verbalise their feelings then they are unaffected by the abuse
- a lack of understanding of what constitutes sexual assault on the part of victim, carers or service providers (which is compounded if abuse is normalised as part of the provision of intimate care)
- victims and families not being aware of how to make a report when they have concerns about sexual assault, or fear of the consequence if they do so in terms of access to care, supported accommodation, and other support resources
- the practice of grooming behaviours on the part of those who engage in sexual offending towards victims, families/carers and other staff in supported accommodation settings.

## **11.2 Responding to referrals of people with disability**

When responding to referrals for people with disability who have been, or suspected to have been, sexually assaulted, SASs will:

- Ensure that all SAS staff have an understanding of indicators and dynamics of sexual abuse for people with a disability, including responding to disclosures and/or behavioural or physical indicators of sexual assault.
- Have the capacity to assess communication needs and have access to tools to both increase capacity and assist in communicating with clients with intellectual and/or sensory impairments.
- Ascertain whether there is a trusted support person available to facilitate access to and/or attend the assessment.
- Identify any potential opportunities to build relationships, share skills and expertise to break down service silos and ensure the person with a disability is provided with coordinated services.

### **11.3 Information gathering in preparation for a SAS response**

The following information will be gathered in preparation for a SAS response for a person with a disability in addition to the information usually sought during referral:

- whether the person is able to provide information themselves. Care is to be taken to not make assumptions about the accuracy and fullness of the referral information (if not self-referral) as well as the importance of 'checking out' information with the person referred.
- with the appropriate consent, specific relevant information about the person's (dis)abilities and what to put in place to maximise communication.
- whether the person has medical or other health care needs that might affect their engagement with SAS staff or the services provided.
- information about who the person lives with, their care needs, who provides this care, and who else they have regular contact with.

### **11.4 SAS psychosocial responses for people with disability**

The provision of counselling for people with intellectual, cognitive and sensory impairment and communication difficulties requires planning. There are a number of resources available to assist SAS counsellors, including *Myalla* (Blyth, 2002) which sets out the following therapeutic principles in counselling:

- Maintain a focus on the client (and not, for example, a carer or support person), particularly when there are communication difficulties to overcome.
- Affirm the client's right to make choices and decisions wherever possible. This may be limited by NSW Health staff's reporting obligations, including child protection requirements and reportable conduct reporting to the NSW Ombudsman.
- Recognise and work with the client's abilities, communication patterns and everyday skills.
- Modify usual counselling strategies, adapting as required — e.g. validating the person's disclosure of the sexual assault, their fears and beliefs about the sexual assault, assessing impact of the sexual abuse on their emotional wellbeing and sense of safety, and developing strategies with the person and their support network to address their ongoing sexual safety (Family Planning Victoria, 2016).
- Provide information and support as required through the investigation and any court processes.<sup>12</sup>

Advocacy and casework is a key role for the SAS in working with a person with a disability in any type of intervention (see also [Section 16.5](#)). Consideration of the client's current and ongoing safety needs is paramount in undertaking this role.

This client group may be in particular need of support, advocacy and casework in reporting the sexual assault, making a statement to NSW Police/JCPRP, participating in the criminal justice system as a victim/witness, and accessing their rights and entitlements as victims of crime. With the patient's consent, the SAS's advocacy and case management role may include:

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<sup>12</sup> NSW Department of Communities and Justice is currently supporting the introduction of witness intermediaries who are available to support vulnerable children and young people making statements to Police and at court.

- liaison and advocacy with parents/carers and support service staff in determining the current safety needs of the client, and whether they are physically and psychologically safe in their current residence/placement
- liaison and advocacy with NSW Police/JCPRP/DCJ and, as appropriate, disability support services
- the SAS being proactive in its outreach to the client and parent/carer/disability support service.

### **11.5 Crisis response for a person with a disability**

Where a person with a disability requires a crisis response ([Section 14](#)), in addition to the above considerations, the SAS staff will:

- liaise with referrers and/or the person themselves about the timing for the initial assessment ([Section 13.5.2](#)), taking into account the psychological wellbeing of the person who has been sexually assaulted.
- empower the person who has been assaulted in their decision-making as much as possible, with the aim of supporting their ongoing safety and wellbeing and access to the criminal justice system
- understand that people with a disability who choose to have a medical or forensic examination may never have had a genital examination before and have little knowledge about their anatomy (ECAV & NSW Health, 2013). It is therefore extremely important that the medical examination is done with the ongoing consent of the person and with ongoing communication and explanation of what is taking place.

## PART THREE: SEXUAL ASSAULT SERVICES RESPONSES

### 12 OVERVIEW OF SEXUAL ASSAULT SERVICES SERVICE MODEL

#### 12 Overview of Sexual Assault Services (SASs) service model: summary

- There are seven key elements of the SAS service model, which often overlap in practice:
  1. crisis response
  2. medical and forensic services
  3. ongoing counselling and other therapeutic interventions
  4. systems advocacy
  5. court preparation and support
  6. professional consultation and training
  7. community engagement, education and prevention.
- All SASs will comply with the forthcoming NSW Health Violence, Abuse and Neglect (VAN) Service Standards.
- There are minimum requirements for SASs that align with the [Guide to the Role Delineation of Clinical Services](#). These include that every district will at a minimum have one Level 4 (or Level 6) SAS within their geographic boundaries that provides 24-hour integrated psychosocial, medical and forensic crisis responses for both adults and children as well as the full range of other elements in the SAS model identified above. For a service to qualify as a designated Level 4 SAS, it will meet the identified minimum requirements.
- SAS clients will usually follow the standard client referral and service response pathway consistent with other NSW Health VAN services.

#### 12.1 SAS service model: seven key elements

SASs will provide the seven key elements of the SAS service model listed below and also represented in Figure 10 (which shows the connections between the elements), noting that activities within these elements often overlap in practice. Each of these seven elements has its own section as indicated in this part of the policy and procedures, with detailed guidance for clinicians on implementation of each element of the model.

**1. Crisis response: a 24-hour service ([Section 14](#)):** Focused predominantly, but not exclusively, on people who have experienced recent sexual assault (occurring in the past seven days), the crisis response is an integrated psychosocial, medical and forensic response with three main elements: 1. coordinating the overall care of the client commencing with an initial assessment, 2. providing crisis counselling, information, support, advocacy, and referral as appropriate, and 3. providing medical and forensic services.

**2. Medical and forensic services: 24-hour and follow-up care ([Section 15](#)):** The medical and forensic service will: identify medical treatment needs not addressed through ED triage; provide information, support and reassurance in a trauma-informed manner; provide medical and forensic

examinations; collect evidence related to the assault through the medical and/or medical and forensic examination for legal purposes, including child protection and care proceedings; dispense or ensure the provision of prophylactic risk assessment, medication and management if required; provide information and follow-up (where provided by the district/network) and/or referral for other medical and health needs as appropriate; and provide the legal system with expert certificates and other expert opinion in the prosecution of sexual assault matters.

**3. Ongoing therapeutic interventions ([Section 16](#)):** SASs offer trauma-informed ongoing counselling and other therapeutic psychosocial services to victims of sexual assault; children with PHSB; and family, significant others or carers. The main psychosocial services offered by SAS are: assessment; safety planning; ongoing counselling and group work; providing information and support, for example, about the justice system or attending a police interview as a support person; and client advocacy and casework.

**4. Court preparation, court support and legal reports ([Section 17](#)):** SAS will provide the following services to facilitate a victim/witness's active and meaningful participation in the criminal justice system and other legal processes: court preparation; court support; debriefing after court; information about their rights as a witness, entitlements to Victims of Crime recognition payments, and inclusion on the Victims Register; assistance in preparing reports such as victim impact statements; provision of expert legal reports to support the prosecution of sexual assault offences or increase the safety of victims; and support with Victims of Crime recognition applications and reports.

**5. Systems advocacy ([Section 18](#)):** SAS will provide systems advocacy to seek to influence or change systems, such as legislation, policy, or practices to positively impact on the client group as a whole, rather than individual cases. Systems advocacy is usually informed by the experiences of the client group and so intersects with client advocacy (see Section 16.4).

**6. Professional consultation and training ([Section 19](#)):** SAS will provide local<sup>13</sup> activities, including: specialist consultation, information and advice to health professionals and other professionals/service providers; local training on working with the SAS client group (see Section 1.5.1) to a range of professionals within and outside the health system; and liaising within their district/network to identify training priorities for staff in relation to sexual assault, including the delivery of trauma-informed services, increased awareness of complex trauma, and collaborative work across service streams. This may include working with ECAV to request and coordinate training.

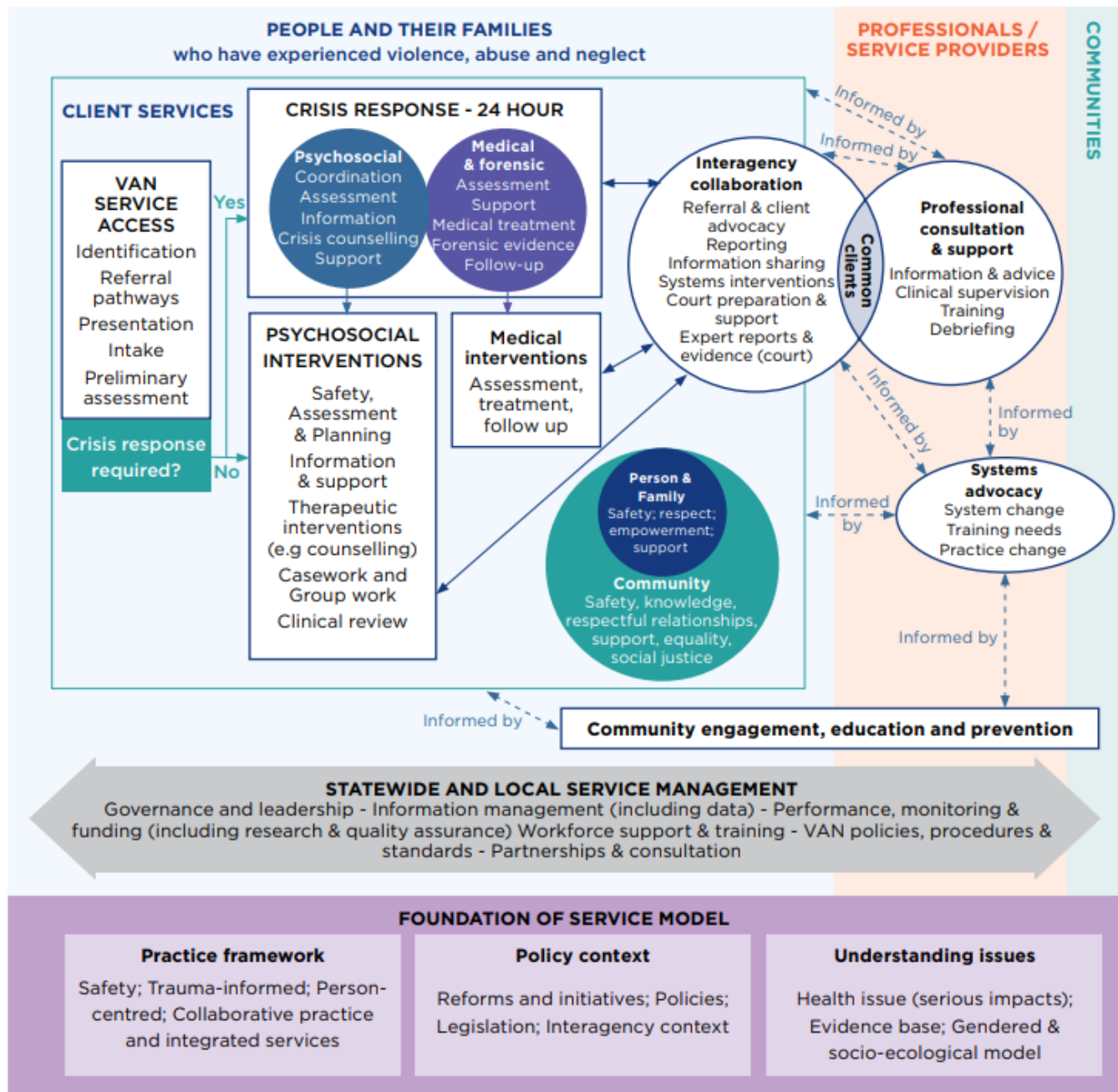
**7. Community engagement, education and prevention ([Section 20](#)):** SAS will provide prevention, community engagement and education to community members about the nature, dynamics and impact of sexual assault, which contributes to: prevention activities; addressing misconceptions about sexual assault in the community; making information about services readily available; increasing understanding about the nature and prevalence of sexual assault; and facilitating support and understanding for people who have experienced sexual assault.

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<sup>13</sup> In NSW Health, statewide training is provided by the [ECAV](#).



Figure 10: VAN service (including SAS) service model (from [IPARVAN Framework](#), p. 77)



## 12.2 Minimum requirements for SASs

All SASs will comply with the forthcoming NSW Health VAN Service Standards. In addition, SASs will be provided in accordance with the framework for clinical services outlined in the NSW Health [Guide to the Role Delineation of Clinical Services](#) (the Guide) ([Appendix 6](#)). Each district/network will use the Guide to plan and deliver clinical services to the level appropriate to meet the needs of the population in their catchment.

Every district will, at a minimum, have a Level 4 (or Level 6) SAS within their geographic boundaries in accordance with the Guide that provides 24-hour integrated psychosocial, medical

and forensic crisis responses for both adults and children, as well as the full range of other elements in the SAS model identified above.<sup>14</sup> Services for adults and children may be provided within the one location or in two separate locations. For districts contracting all of their 24-hour SAS crisis functions from outside their district, these services will be provided within the district boundaries in appropriate facilities that meet the requirements of this policy and procedures (see [Section 23.2](#)).

Districts will provide services as close to home (or other places of significance to the client — e.g. work, school, or where the assault occurred) as possible for people and their families/significant others. The provision of more than one 24-hour service (e.g. in another Level 4 or Level 3 service) and/or outreach follow-up, and ongoing counselling and therapeutic interventions, within a district's boundaries is encouraged. It may also be appropriate for districts to have in place agreements with neighbouring districts or cross-border arrangements to make services more accessible. Where such arrangements are in place, they will not be in lieu of the provision of at least one 24-hour (adult and child) SAS within the district boundaries. Where districts/networks have in place arrangements for another service to provide some or all of their SAS functions, that other service will comply with relevant sections of this policy and procedures in providing those services.

For a SAS to qualify as a Level 4 service it will meet the following minimum requirements:

- a SAS manager or clinical lead ([Section 23.6.3](#))
- a medical director ([Sections 15.1.4 & 23.6.3](#))
- designated qualified and appropriately trained SAS counsellors to work with children, young people and adults who have been sexually assaulted, children with PHSB, and family members, carers and significant others of those groups ([Section 23.6.3](#))
- provision of high-quality, timely, 24-hour crisis response, including coordination, counselling and support ([Section 14](#))
- provision of high-quality, timely, 24-hour medical or medical and forensic services for examinations, treatment and follow-up by appropriately trained doctors and SANEs ([Section 15](#))
- provision of counselling, group work and other evidence-informed psychosocial interventions as well as court preparation and support ([Sections 16](#) and [17](#))
- provision of individual and systems advocacy including attendance and/or participation in relevant interagency forums or case planning meetings with interagency partners to ensure integrated service delivery ([Sections 16.5](#) and [18](#))
- provision of professional consultation and training ([Section 19](#))
- provision of community engagement, education and prevention ([Section 20](#))
- management support and clinical supervision for SAS counsellors and medical and forensic examiners by suitably qualified staff ([Section 23.6](#))
- a peer review program for medical and forensic services ([Section 15.14.4](#))

<sup>14</sup> An exemption for existing service delivery arrangements that do not meet this requirement may be granted by the Secretary, Ministry of Health in writing.

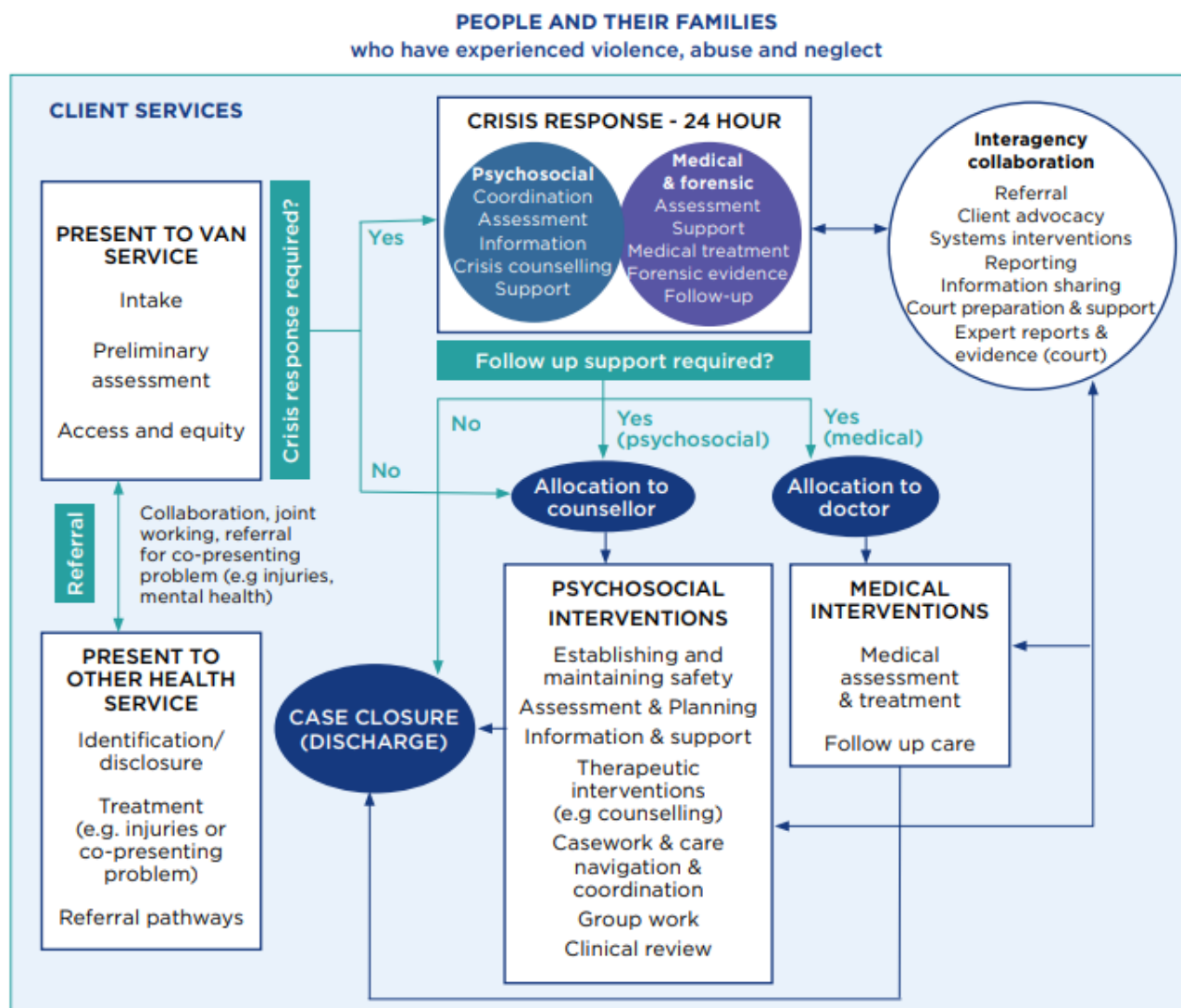
- appropriate physical facilities and environment ([Section 23.2](#)).

### 12.3 Overview of the client service pathway

SAS clients will usually follow the standard client referral and service response pathway for VAN services depicted in Figure 11 below.

**Figure 11: Standard VAN services client pathway**

(reproduced from [IPARVAN Framework](#), p. 88)



## 13 SERVICE ACCESS

### 13 Service access: summary

- SASs will have developed local protocols and procedures to ensure appropriate, trauma-informed and efficient incoming referral processes for people who meet their service criteria with other agencies.
- SASs aim to provide services and programs that: promote equity of service access; are timely and physically easily accessible within urban, regional and rural areas; demonstrate knowledge and understanding of the range of diverse needs within the community and build trust in a way that reflects cultural and situational factors; and are non-discriminatory, equitable, flexible and respectful. To achieve this, SAS will put in place various measures to help facilitate service access.
- SASs will have documented local intake procedures to help ensure minimal delay in the referral of the victim to the SAS.
- SASs will seek consent for SAS responses in accordance with relevant NSW Health statewide policy. In particular, appropriate consent will be obtained that is freely given, sufficiently specific, timely, and informed.
- Assessment is an important component of the SAS response and involves four main types: initial assessment; medical and forensic assessment; comprehensive psychosocial assessment; and ongoing informal clinical assessments across all interventions. SASs will take a dynamic approach to assessment that includes ongoing safety and risk assessment as a key component.
- SASs will prioritise client allocation based on the clinical assessment of safety and need identified in the initial assessment. Where client need is assessed as equal and prioritisation is required (e.g. due to insufficient resources) SASs will follow the identified nine priorities for client allocation.

### 13.1 Referrals

#### 13.1.1 Service criteria

Referrals may be made to SASs for the following groups:

1. children and young people:
  - who have been sexually assaulted recently or in the past
  - who are under 10 years old with PHSB, where the PHSB is the primary presenting issue (regardless of whether or not the child has experienced sexual assault)
  - for whom a JCPRP health worker has identified through a clinical assessment and consultation with interagency partners (NSW Police and/or DCJ) that they may have been sexually assaulted or are likely to benefit from a SAS intervention.
2. adults who have been sexually assaulted recently or in the past, including as a child.
3. family members, significant others and carers of both groups listed above.

### **13.1.2 Referrals from other agencies**

SASs will have developed local protocols and procedures to ensure appropriate, trauma-informed and efficient incoming referral processes with other agencies. These protocols are to reflect statewide requirements outlined below for particular referral sources and types of referrals. Procedures for referrals will cover issues of consent, information sharing without consent, confidentiality and, where appropriate, feedback on the outcome of the referral in accordance with information sharing considerations ([Section 22.2](#)).

Referring agencies may contact and consult with SASs for new referrals. Where a SAS is contacted out of normal hours (5:00pm-8:30am normal weekdays, all weekends or public holidays) in relation to the referral of a person who was sexually assaulted within the past seven days or for someone who would otherwise meet the criteria for a SAS crisis response ([Section 14](#)), local referral and intake arrangements within NSW Health are to ensure that the on-call SAS counsellor is notified prior to the person's arrival if local factors (e.g. substantial travel time for the counsellor) necessitate this to minimise delays in providing care. Referring agencies will be asked to alert the SAS counsellor to any particular needs of the client, as outlined in local protocols (e.g. an interpreter, Indigenous status of the client, access needs).

Where a referral does not result in service provision, the SAS will aim to re-contact the client to identify and address any problems or blockages to a successful referral. For example, a phone call to the client may identify cultural or practical issues that need to be addressed for the client to receive an appropriate response from the SAS.

### **13.1.3 Referrals between Sexual Assault Services**

Pathways and communication lines will be set up between the different SAS sites across the state, particularly, although not exclusively, those in neighbouring districts, to allow sharing of information, with the appropriate consents in place, especially in the context of people with complex needs and specific care requirements.

Referrals between SASs in two different districts/networks will usually be 'warm' referrals. This means that, with the appropriate consent, the referring SAS contacts the SAS that is being referred to on the client's behalf and provides a detailed handover. This handover is to include the provision of appropriate written material such as case notes and other documentation to support the SAS that is being referred to, thus providing the person with a seamless, appropriate and comprehensive response.

### **13.1.4 Other VAN services Child Protection Counselling Services (CPCS)**

If a referral to a SAS is for a person who also meets the eligibility and prioritisation criteria for another NSW Health VAN service (e.g. Child Protection Counselling Service [CPCS] (see [Child Protection Counselling Services Policy and Procedures](#)), integrated VAN service, or domestic and family violence service), discussions will occur between the referrer, the relevant VAN services, and the relevant SAS to determine which is the most appropriate service. For example, in the case of CPCS, if the primary goal of referral is to help the child recover from the experience of sexual assault, then the SAS is likely to be more appropriate. If the primary goal is to support family preservation, restoration or sustainability of placement, then CPCS may be the most appropriate service.



There may be occasions where more than one VAN service is involved with a person or family. Where this is the case, there will be clear agreement of each service's roles and responsibilities, which is documented and regularly reviewed. The services will work collaboratively in accordance with the appropriate consents for the situation.

### **13.1.5 Referrals of clients with two or more presenting issues**

If a referral meets the service criteria for SAS ([Section 13.1.1](#)) and there are two or more presenting issues that mean the person could be eligible for or require other NSW Health services (apart from VAN services identified above), the SAS counsellor will work with the person, referrer, and/or their family/carer (as appropriate) to identify the primary presenting issue. Where it is difficult to isolate a primary presenting issue, it may be necessary for the SAS to consult with other NSW Health services and/or undertake joint intake processes/assessment to determine which service is most appropriate to take the lead with that person and what role, if any, the other service might play to support them (e.g. joint clinical work or information and advice on the secondary presenting issue). In cases where both services will work with the person, clear agreement of each service's roles and responsibilities will be documented and regularly reviewed and the services will work collaboratively.

### **13.1.6 Referral of multiple recent sexual assault victims.**

In cases where there are multiple recent victims of sexual assault (that is, a number of victims assaulted by the same perpetrator or a group of victims assaulted in the same incident), and the crisis response is beyond the capacity of the one SAS, the on-call SAS counsellor and/or on-call counselling supervisor or other more senior staff member (as appropriate) will consult with the medical and forensic examiner and subsequently with the district/network's executive team to plan a comprehensive response and prioritisation of district/network resources. The district/network may need to consider requesting assistance from a SAS outside of the district/network where it is in the interests of the victims and appropriate to do so.

The SAS response will ensure control and coordination of information to ensure that an effective multi-agency and trauma-informed response is provided.

Where there are multiple victims of the same perpetrator, it is preferable that each victim is provided a service by a different SAS counsellor and medical and forensic examiner to avoid contamination of evidence, unless this causes unnecessary delays. Ideally, victims will also be provided a service in different rooms. Where this is not possible, particular care is to be taken to ensure decontamination procedures ([Section 15.8.4](#)) are carried out thoroughly in the SAS rooms (both medical and forensic examination and counselling rooms) between each victim being provided a service.

For referrals of a number of children who have been sexually assaulted in the same institution, the JCPRP process for the establishment of a local contact point are to be followed. The JCPRP Local Management Team (including the JCPRP SHC/HC) in conjunction with JCPRP agency line managers (including the JCPRP health manager) will plan and coordinate the process. This includes the appointment of one JCPRP agency representative to act as local contact point (NSW Police team leader, DCJ JCPRP manager casework or JCPRP SHC/HC, or, as required, JCPRP agency line managers).



SASs are to consider initiating a planning meeting with DCJ/JCPRP or NSW Police and any other relevant agencies. If it is likely that additional resources will be required, the SAS manager or another appropriate person (e.g. the district/network's prevention and response to violence, abuse and neglect [PARVAN] senior executive or senior manager) will provide a confidential brief to the Chief Executive of the district/network to clarify the roles of the agencies involved and identify resources required.

### **13.1.7 Referral of young people 10-17 years old who have engaged in harmful sexual behaviours**

For young people aged 10-17 years old who have engaged in harmful sexual behaviours, SASs do not ordinarily provide services related to their sexually harmful behaviour. SASs will, however, provide a crisis response to a young person who has experienced a recent sexual assault (occurring within the past seven days) as well as provide services in relation to inappropriate and problematic sexual behaviours (i.e. where another person has not been harmed).

In providing a crisis response service to a young person known to have sexually harmed another person, the SAS staff will need to carefully consider and manage any safety and security risks in accordance with the NSW Health policy directive [Protecting People and Property — NSW Health Policy and Standards for Security Risk Management in NSW Health Agencies](#), with particular attention to Chapter 6, 'Security arrangements for patients in custody', if appropriate (see also Section 10 on restricted settings, if appropriate).

It is important that children and young people aged 10-17 years old who have sexually harmed are not referred to as perpetrators. NSW Health policy requires that no NSW Health service may treat young people 10-17 years old for their sexually harmful behaviour other than New Street Services. When a child or young person 10-17 years old with sexually harmful behaviours is referred to a SAS and meets the service criteria or where a child under 10 with PHSB is receiving a service from a SAS and is close to turning 10 years old, discussions are to occur between the referrer (if appropriate), the SAS and New Street as to the nature of the behaviour, which is the most appropriate service to respond, or if referral to a third service is more appropriate.

Where there is no New Street service available or no other more appropriate service to refer to in that area, SAS may choose to accept a referral for a child/young person 10-17 years or continue working with a child with PHSB who turns 10, who otherwise meets both SAS and New Street service criteria. This is provided that the SAS:

1. Consults with New Street and that New Street manager/coordinator approves the SAS working with the client. This approval is to be documented in the case file.
2. Where necessary (particularly where they have limited experience with this client group), the allocated SAS counsellor is provided with information, advice and ongoing support (e.g. supervision) from New Street or another appropriately qualified worker with expertise in this field.
3. The district/network PARVAN senior executive (tier 2/3) responsible for the SAS that accepts the referral provides written approval that the SAS may work with the child/young person and their family/carers. Consideration will also be given to supporting the SAS team to access informal training with New Street to enhance their skills and knowledge of the New Street Practice Model.

### **13.1.8 Referral of adult perpetrators of sexual assault**

Adults who have perpetrated sexual assault or sexually harmed another person will not ordinarily be provided with a response for ongoing therapeutic interventions from a SAS. SASs may however provide a crisis response to an adult who has experienced a recent sexual assault (occurring within the past seven days). However, this response must concern their experience of victimisation only.

In providing a crisis response service to an adult known to have perpetrated sexual assault, the SAS staff will need to carefully consider and manage any safety and security risks in accordance with the NSW Health policy directive [Protecting People and Property — NSW Health Policy and Standards for Security Risk Management in NSW Health Agencies](#), with particular attention to Chapter 6, 'Security arrangements for patients in custody', if appropriate (see [Section 10](#)).

Ongoing therapeutic responses for an adult who has perpetrated sexual assault or sexually harmed another person and has had their own experience of sexual assault are to be provided by an agency other than the SAS (e.g. a Victims Services counsellor who is appropriately trained and accredited to work with perpetrators of sexual assault). The SAS will facilitate a 'warm' referral, where the SAS counsellor directly contacts another service provider and provides a handover to them, to the other service ([Section 13.1.9](#)) and advocate on the person's behalf to receive that service.

Most adults who have perpetrated sexual assault or sexually harmed another person will not have been convicted and will not be on a sex offender register. Most perpetrators of sexual assault will therefore not be identifiable to SASs. Districts and networks will establish universal safety precautions with local policy and procedures that help maximise the safety of all clients accessing their services. This includes, for example, ensuring waiting rooms are supervised by staff at all times and that the SAS adhere to the principles of Child Safe Organisations ([Section 3.3](#) & [Appendix 3](#)).

### **13.1.9 Referrals to other services**

SASs may need to provide referrals to other services, agencies or professionals to ensure a person or family/carer/significant other has access to a range of service responses and assistance that is trauma-informed and suited to their needs. Such referrals may take place at any stage of referral, intake, and through the various interventions and service responses that SASs provide through to case closure.

A referral may be to provide an appropriate service response to the client in collaboration with the SAS response or, instead of this response, in circumstances where a person's needs would better be met by a different service. When the SAS is making a referral, client information will be treated with respect and confidentiality. SASs will develop local protocols and procedures to ensure appropriate outgoing referral processes. Procedures for referrals will cover issues of consent, confidentiality and, where appropriate, feedback on the outcome of the referral.

In local referral protocols and procedures, SASs will adhere to:

- the HRIP Act and the NSW Health [Privacy Manual for Health Information](#)
- the [NSW Charter of Victims' Rights Code of Practice](#), to help ensure victims of crime access their entitlements under the *Victims Support and Rights Act 2013*

- NSW Health [Conflicts of Interest and Gifts and Benefits](#) policy directive
- information-sharing provisions in the [Children and Young Persons \(Care and Protection\) Act 1998](#) and [Crimes \(Domestic and Personal Violence\) Act 2007](#) where consent is not provided ([Section 22.2](#)).

To maximise client engagement, SASs will be diligent and proactive in initiating referrals — for example, by providing ‘warm’ referrals for clients and actively following up on referrals and their outcomes. SASs will work collaboratively with agencies and professionals they refer to where both are providing a service to the same client. In some circumstances, SAS staff may need to adapt their service responses in consultation with the referring agency as appropriate. For example, where a client attending counselling develops acute mental health issues requiring hospitalisation or psychiatric care, the SAS may refer to a mental health service and then work collaboratively with them to continue providing support, such as through casework with the client or professional consultation on responding to sexual assault with the service ([Section 19](#)), until the client is ready to re-engage in counselling.

#### **13.1.10 Referrals to private practitioners**

SASs will ensure that referrals for clients are made in a professional and consistent manner and ethical considerations are addressed where SAS counsellors or medical and forensic examiners (including those on on-call rosters) have a private practice in the same geographical area as the SAS.

When referring potential clients to counsellors or medical officers in private practice, SASs must comply with NSW Health [Conflict of Interest and Gifts and Benefits](#). This includes giving potential clients a list containing at least three names from which to choose.

SAS counsellors and medical and forensic examiners are not to include themselves in this list of names of private practitioners. The [NSW Health Code of Conduct](#) provides further guidance.

Particularly in small rural areas and where a follow-up medical service is not provided by the district, the on-call medical officer may be the most suitable person to undertake follow-up, taking into consideration the privacy and confidentiality concerns that clients may have. Where this is the case, the SAS medical director (or, if the referral concerns them, the medical director’s line manager) is to be consulted to confirm the appropriateness of the referral.

### **13.2 Access and equity**

#### **13.2.1 Promoting access**

SASs aim to provide services and programs that:

- promote equity of service access, including timely availability and physically easy access within urban, regional and rural areas
- demonstrate knowledge and understanding of the range of diverse needs within the community and build trust in a way that reflects cultural and situational factors
- are non-discriminatory, equitable, flexible and respectful.

#### **General issues**

In facilitating service access SAS will:

- Provide services that are free of charge, private and confidential (within the limits of legal requirements, such as those related to safety and child protection).
- Demonstrate sensitivity and respect in relation to issues of age, culture, ability and sexuality when working with children and families.
- Identify and respond to the needs of identified target groups with particular vulnerabilities and barriers to accessing services within the district/network.
- Undertake ongoing participatory planning that involves input and partnerships with consumers, the community and key stakeholders, and draws on SAS client demographic data.
- Develop appropriate procedures and strategies for locally identified groups with particular locally identified disadvantaged or vulnerable groups.
- Ensure the environment reflects the diversity of the community (e.g. posters, pictures, toys, and puzzles reflect the diverse 'faces' of service users).

### ***Aboriginal people and communities***

In recognition of the historic and cumulative impact of colonisation, violence and trauma that Aboriginal people have suffered and the substantial barriers they face in accessing services ([Appendix 8](#)), SASs will:

- Provide physically appropriate space for Aboriginal children, young people, adults, families and communities to come together to receive a SAS response. This may include, for example, the capacity to use available outdoor spaces on occasion.
- Ensure SAS staff receive and update Aboriginal cultural competency and cultural diversity training.
- Ensure recruitment practices are aligned with the Aboriginal employment strategy, provide pathways to support employees to obtain qualifications (e.g. ECAV VET qualifications and University of Sydney Graduate Certificate), and facilitate the further development of identified positions.
- SAS will try to make Aboriginal workers available to undertake culturally appropriate intake, referral, assessment and service responses to Aboriginal people and communities.
- Identify and build relationships with Aboriginal cultural consultants and Aboriginal communities, including engaging with elders and other leaders (see [Section 21](#)), ensuring that access is promoted through liaison with Aboriginal Family Health Workers and consultation with Aboriginal workers and cultural advisers throughout all service responses as appropriate.
- Clarify if English is a family's only language and, if not, consult with appropriate Aboriginal workers or organisations about how to access interpreters and translations for these families. Aboriginal English is frequently used and illustrates the importance of workers having regular access to cultural consultants.

### ***Interpreter services***

SAS will be guided by the NSW Health policy [Interpreters — Standard Procedures for Working with Health Care Interpreters](#). SASs will:

- Ensure information about the use of professional interpreters, including telephone interpreters, is available to staff and that all staff receive training in the use of interpreters.
- Ensure that interpreter services are used for all clients who are not fluent in spoken English, in accordance with NSW Health policy (see further below). Cultural and pre-migration trauma may influence family engagement with any public agency and may interfere with a client accepting a professional health care interpreter. It is important that workers sensitively approach this issue, as clients may be reluctant due to fear of stigma, mistrust of authority or other concerns due to past experiences.
- In using health care interpreters SAS staff will:
  - Consider the gender of the interpreter appropriate for the circumstances.
  - Consider the cultural background of the interpreter as well as their language background to ensure that clients are not provided with someone from an inappropriate cultural background (e.g. someone who may represent the community of the oppressor in their country of origin).
  - Consider using telephone interpreters over face-to-face interpreters if preferred by client, due to the stigma and shame associated with sexual assault.
  - Recognise that the availability of qualified interpreters in some small and emerging communities may be very limited. The same interpreter could be used for providing language assistance to the client in the health setting as well as the accused in the legal environment.
  - Ensuring interpreters are adequately briefed before and after sessions where possible (noting that the opportunities for this in a crisis response setting may be limited).
  - Recognise the experience of vicarious trauma by interpreters and ensure adequate supports are in place.

### ***Active involvement of people with disability***

A person's right to participate in decision-making about their life is fundamental to their independence and dignity. All reasonable steps need to be taken to support people with disability with communication regarding services provided, information sharing, assessment, planning and interventions. For communication access needs in addition to interpreting services identified above, SASs will:

- Provide a teletypewriter (TTY) facility for clients who are deaf or hard of hearing where possible.
- Use Auslan/English Interpreters for clients who are deaf or hard of hearing where possible and where requested by the client.
- Where possible, use direct and clear language, alternative communication methods, visual and other tools and devices (e.g. communication boards, information pictures), as indicated by client need and preference and/or by consulting with specialist agencies regarding these needs.

### ***Geographic and physical access issues***

SASs will:



- Be located close to public transport where possible.
- Ensure the physical environment is accessible for people with disability and/or organise alternative and more accessible locations dependent on the person's needs.
- Address access and equity issues associated with district boundaries, taking account of clinical need and service capacity — for example, clients moving out of the district who wish to remain with the original service, or clients who work within the district but reside outside of it.
- Provide outreach locations especially for rural and regional areas ([Section 13.2.2](#))

### **13.2.2 Outreach**

Providing services at alternative locations (outreach or inreach into secure facilities) or through other means (e.g. telehealth), particularly in rural areas and small communities, may improve accessibility, provide a more welcoming environment, and encourage client engagement and participation. SASs may provide outreach services where there is a client need and in accordance with relevant NSW Health policy, standards and guidelines. Outreach services are typically offered in regional and remote areas, and in some circumstances are also offered in metropolitan areas to improve access and promote engagement. Outreach services are typically only provided for psychosocial services unless appropriate health facilities are available for a medical and forensic response ([Section 15](#)).

In providing outreach, districts/networks will ensure:

- Outreach services are only offered if the sexual assault worker's safety has been assessed and addressed, consistent with the [NSW Health Work Health and Safety: Better Practice Procedures](#) and [NSW Health Protecting People and Property: NSW Health Policy and Standards on Security Risk Management for NSW Health Agencies](#).
- Clinical judgement and the clients' preference will influence the location of service delivery. It is also important to give attention to issues of privacy, clarity of role and client and worker safety when considering whether or not outreach is appropriate. The outreach service needs to take place in a location and environment that is accessible, appropriate and safe for the client and worker. The location of an outreach service also needs to take account of what type of physical space is most suitable to facilitate the optimal type of therapeutic intervention. This may include home visits and/or appointments with clients in appropriate local agencies such as community health centres, other health facilities, Community Service Centres, out-of-home-care agencies and other safe locations preferred by the clients.
- The hours of operation and means of accessing the outreach service are accessible.
- Outreach services involve increased costs and should be appropriately resourced.
- Services may use a range of media and technology to ensure their service is accessible to their clients in accordance with NSW Health and district/network policy requirements. For example, teleconferencing or videoconferencing may be considered as an alternative to outreach where appropriate.
- Where possible, SASs in rural and regional areas will develop a schedule of circuits to improve the efficiency of outreach services.
- Clients who have outreach appointments will be given the name of one SAS counsellor to make arrangements for, or changes to, appointments.



### **Worker safety**

Worker safety issues associated with outreach must be addressed within each SAS, taking account of specific district/network circumstances such as the quality of roads, the distances required, the location of the office, access to public transport and the range of other services and general infrastructure available. Worker safety is a shared responsibility between the organisation and the individual staff member. The organisation must have clearly articulated policies and ensure staff members are aware of these and comply with these policies. In addition to the relevant NSW Health policies identified above, districts/networks will ensure:

- Each SAS will have a local procedure for confirming that a worker who has undertaken a home visit has left the home safely.
- The SAS manager/coordinator is responsible for ensuring priority is given to the safety and wellbeing of workers in assessing whether to conduct home visits.
- If the family has experienced domestic and family violence, a safety and risk assessment regarding the presence of current risk factors must be undertaken, including whether the person alleged or confirmed to have used violence is in the house or continues to have contact with family members at the home, and what safety strategies can be put in place to ensure worker safety.
- A safety assessment conducted prior to a home visit may require a worker to obtain additional information from NSW Police, DCJ, CWUs or other agencies and from health records.

#### **13.2.3 Proactive engagement**

SASs are responsible for the promotion of access and engagement of people who have experienced sexual assault and their family/significant others. This involves taking a non-judgemental, proactive and creative approach to engaging people with their services (Berry Street, 2015). Proactive engagement involves being respectful, creative, persistent, assertive and adaptive, which is important to help maximise the engagement of people with the therapeutic process. A collaborative approach to the therapeutic alliance, which includes effective engagement and relationship building with adults, children, young people, families, carers, significant others and the broader service system, is a key factor to effective intervention (Schley, Yuen, Fletcher, & Radovini, 2012). Given the nature and dynamics of sexual assault, SASs will need to pay particular attention to build and demonstrate trust and trustworthiness. Building a trusting relationship creates a sense of physical, emotional and cultural safety, and requires being honest, predictable and consistent.

#### **13.2.4 Collaboration with other services**

Collaborative practice and integrated service delivery is a key element of good practice in responding to sexual assault. SASs will maintain close interagency relationships and collaborate to provide coordinated, effective services and to promote quality service responses and continuity of care to people who have experienced sexual assault and their families/significant others. While tailoring responses to local needs and conditions, SASs will operate within the context of interagency agreements and will at a minimum:

- Ensure all SAS staff are familiar with and adhere to relevant legislation and policy, including the *Interagency Guidelines for Responding to Adult Victims of Sexual Assault* and the [Child Wellbeing and Child Protection — NSW Interagency Guidelines](#).

- Establish and maintain processes to ensure ongoing collaboration with interagency partners that gives priority to the needs of clients. SASs may take the lead in collaborative work or support the lead of other agencies, depending on the nature of the collaboration, client need, agreements with the client, and service capacity. This may include the development of service agreements that clearly define each agency's roles and responsibilities, including who holds primary clinical responsibility. Of particular note here is the importance of developing and sustaining respectful and effective collaborative relationships with Aboriginal organisations ([Section 21](#)).
- Share information related to cases in accordance with legislation and policy.
- In accordance with relevant legislation and policy, obtain written consent from the client (where appropriate) before collaborative work commences, including consent to which agencies will be involved and the level of and content of information shared between agencies.
- Initiate and/or participate in meetings such as case-planning in relation to the safety, protection and ongoing care and support of SAS clients. This is of particular importance if it concerns clients with special needs, such as a physical or intellectual disability or mental illness. Where possible, the client will be informed and invited to participate if appropriate.
- Support clinicians to participate in appropriate local committees relating to sexual assault victim support, domestic and family violence, child protection and other relevant local management committees.
- Support SAS managers and workers, as appropriate, to participate in appropriate local committees, interest groups, interagency networks and other initiatives relating to sexual assault victim support, domestic and family violence, child protection, and other relevant issues.
- Ensure any community education and prevention activities are conducted in partnership with communities and government and non-government agencies, including observing culturally appropriate protocols for the relevant community.

### **13.3 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' (NASASV, 2015, p. 41). SASs will have documented local intake procedures to help ensure minimal delay in the referral of the victim to the SAS.

The SAS's intake is to be provided by the SAS counsellor where possible. In smaller services where a dedicated intake service is not available, SASs will train intake workers and provide clear guidelines and support on gathering referral information in a sensitive and trauma-informed manner and, as appropriate for their skill set, some level of initial assessment to ensure any urgent matters are identified and responded to appropriately.

The intake process will ordinarily consist of, at a minimum, identifying and recording:

1. nature and details of referrer and referral (where not a self-referral)
2. identifying and demographic information about client (e.g. name; self-identified gender; date of birth; Medical Record Number, if available; address; contact details; Aboriginality status; country of birth)

3. limited details about nature of assault/s related to service eligibility, to determine the nature of the service response and pathway (e.g. recent sexual assault, victim of sexual assault in crisis, past sexual assault), and to provide guidance on the use of an EEK for preservation of evidence if necessary to aid patient comfort (e.g. being able to drink/eat and use the toilet)
4. any communication, consent or access needs (e.g. whether an interpreter is required or other cultural diversity considerations; whether the client is able to consent to a service and/or whether the client is medically fit to receive a SAS response in the case of a recent sexual assault; disability; Aboriginality; LGBTQI identification; and any other potential access-related needs)
5. other information essential to the client's current needs and/or emotional status.

Some initial assessment ([Section 13.5.2](#)) will take place at the time of intake to ensure an appropriate response to urgent matters (e.g. if a crisis response is required), but the depth of this initial assessment will depend in part on who is undertaking the intake process and the circumstances (e.g. whether a SAS counsellor and whether the initial information necessitates a crisis response, in which case the majority of the initial assessment will likely be undertaken by the SAS counsellor during the crisis response).

Where the SAS intake worker determines that a person presents a risk to themselves or others, they will refer to mental health services, ED, NSW Police and/or NSW Ambulance, depending on the circumstances and as a matter of priority. This is in addition to any reporting obligations set out in Section 4 of these policy and procedures. The SAS will continue contact with the person in collaboration with the service they are referred to and provide direct services if appropriate, as well as referring them to any other supports or services that may be appropriate ([Section 13.1.9](#)).

### **13.4 Consent**

This section refers to general consent for services provided by SASs. Specific guidance on consent for medical or medical and forensic responses is provided in [Section 15.6](#).

SAS will seek consent for SAS responses in accordance with relevant NSW Health statewide policy, including the *Consent to Medical Treatment Manual*. Consent must, as a general rule, be sought in the first instance from the patient themselves if possible. People are to be assumed to have capacity to consent unless it is demonstrated they do not have capacity. Generally, a person has capacity to consent if they can:

- understand the facts and the choices involved
- weigh up the consequences, and
- communicate the decision ([Capacity Toolkit](#)).

SASs can be informed by the following capacity assessment principles from the [Capacity Toolkit](#) in determining whether someone can consent:

1. always assume a person has capacity
2. capacity is decision-specific
3. don't assume a person lacks capacity based on appearances
4. Assess the person's decision-making ability — not the decision they make

5. respect a person's privacy
6. substitute decision-making is a last resort.

Even in circumstances where a person isn't able to formally consent (e.g. a younger child), it is best practice to seek informal consent and willingness to participate directly from the client in addition to any formal consent required.

Consent must be freely given, sufficiently specific, timely, and informed. This includes providing relevant information regarding confidentiality and its limits (e.g. child protection and police reporting requirements — [Section 4](#)), services provided, information sharing, assessment, planning and interventions. Relevant information must be provided in a way that best enables the information to be understood. This includes a clear explanation of the SAS role and what can be expected during SAS involvement. For people and families from Aboriginal and culturally and linguistically diverse backgrounds, consideration will be given to involving a cultural consultant or cultural organisation when establishing consent ([Section 21](#)).

If a child or young person is living in OOH, the same principles of transparency, honesty and respect apply to interactions with their carers. While the carers are not officially providing consent, building a positive working relationship through engagement and relevant and appropriate sharing of information maximises collaboration. Carers in the context of OOH do not have the right to refuse a service for the child/young person, but they can refuse consent for their own participation.

There is to be evidence in the client's counselling records<sup>15</sup> of discussion about consent, the person's agreement to participate, or other ways the SAS has received authorisation to proceed.

### **13.5 Assessment**

Assessment for the purpose of this policy and procedures refers to an evaluation of the safety and wellbeing of all involved (the client and others such as children in their care and professionals providing a service to them) as well as of the client's mental, physical, social, psychological, emotional, medical and forensic needs.

Assessment, no matter how brief, allows a relationship to start, or continue, to be built and expectations to form. It helps to promote client and worker engagement and guide the direction of interventions. Clinical assessments (psychosocial and medical and forensic) must not be a static, one-off process. Rather, good practice requires an ongoing dynamic process of assessment, analysis, review and response by the clinician/s in partnership with the client/patient and other professionals. Such assessments may be formal or informal and will take place during each individual intervention, as well as across multiple interventions or interactions with the person.

Consistent with this dynamic and collaborative approach to assessment, information provided about assessment is designed to be transformative, rather than simply a process of collecting information. The manner in which questions are asked has therapeutic purposes and intentions.

There are four main types of assessment referred to at various points in this document:

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<sup>15</sup> As identified above, consent for medical and forensic examinations, including documentation requirements, is provided at [Section 15.6](#).

1. initial assessment
2. medical and forensic assessment
3. comprehensive psychosocial assessment
4. ongoing informal clinical assessments across all types of interventions.

### **13.5.1 Safety and risk assessment and management**

At the time of accepting the referral, the SASs will assist in reducing risk and increasing safety for the person referred, in collaboration with the referrer, the family/significant others, and other agencies. Although this will usually be in relation to sexual assault, it can also be about other potential risks, such as:

- the person's behaviour placing themselves at risk (such as absconding, substance use, self-harm, suicide)
- the person being exposed to risk in community (such as sexual exploitation, community violence, racial discrimination)
- the person's behaviour posing a risk to the community (such as fire lighting, harmful sexual behaviour or violence to others)
- the person or their family being exposed to risk through domestic and family violence (include consideration of location and risk of perpetrator)
- risk to SAS staff posed by the client or family/significant other (worker safety).

Risk assessment and management is undertaken through a shared collaborative approach with the client themselves and other services involved, in accordance with the necessary consents required. The SAS approach to risk and safety is a continual process of assessing, establishing, and monitoring physical and psychological safety at each point from intake to case closure. Assessment of risk generally includes two elements:

- What is the likelihood that a type of risk will occur?
- What is the possible degree and type of harm resulting from the risk?

Assessing risk and establishing safety will not be limited to the person referred but also take into account others who may be at risk, including siblings, other relevant children, parents, partners, extended family members, carers and significant others.

In assessing and responding to safety and risk, SAS staff will be guided by NSW Health policy including, but not limited to:

- [Clinical Care of People Who May Be Suicidal](#)
- [Child Wellbeing and Child Protection Policies and Procedures for NSW Health](#)
- [Domestic Violence — Identifying and Responding](#)
- [National Risk Assessment Principles for Domestic and Family Violence](#)
- [Protecting People and Property — NSW Health Policy and Standards for Security Risk Management](#)

The dynamic nature of assessment is important for safety, as circumstances may undergo rapid and frequent change, which alters the nature and severity of the risk and thus necessitates ongoing or continuous assessment. Safety and risk assessment forms an integral part of all four of



the types of assessment in [Section 13.5](#). SAS staff will continually monitor and assess changes in circumstances that may impact on safety and risk to the person themselves or others and act accordingly, e.g. by undertaking and implementing safety planning; liaising or reporting to NSW Police or DCJ; or referring to and engaging with mental health and other appropriate services.

### ***Domestic and family violence***

Sexual assault in the context of intimate partner violence is the strongest indicator of escalating frequency and severity of violence in that relationship and is linked to lethality (Backhouse and Toivonen, 2018). Assessing risk and safety in this context, including in partnership with the person who has experienced domestic and family violence, is critical and may be facilitated through the use of a structured professional judgement approach.<sup>16</sup> Where safety and risk issues are of concern in the context of domestic and family violence, discussion with the client can include to:

- address issues that might facilitate or hinder safety
- ensure up-to-date, appropriate and achievable safety plans with resources and supports
- assist clients to make informed decisions but always acknowledge their own expertise in managing their safety and the safety of their children
- with their active agreement, refer clients to appropriate domestic and family violence services or other appropriate services
- ensure information is exchanged with other professionals, with appropriate consent, and is acted upon to assist with ongoing risk assessment and management.

### ***Children and young people***

Where safety concerns are identified with children and young people at any point in the SAS intervention, these issues can sometimes be raised and addressed directly with parents/carers, and the work with children, young people and the family can proceed, while maintaining attention to both the experience of the sexual abuse and the ongoing experiences of harm. In other cases, the support of DCJ may be required to establish or re-establish a safety framework — or, if this is not possible, to remove the child or young person from an unsafe environment. Where a child or young person is considered to be at current risk of significant harm during any intervention, the SAS counsellor will act in accordance with mandatory reporting requirements ([Section 4](#)).

### ***Suicidality***

SAS counsellors will understand suicidal ideation and be trained and supported to respond appropriately to clients who identify or display these safety concerns. When a client is expressing suicidal thoughts or has disclosed a plan to commit suicide, SAS counsellors must be proactive in safeguarding their immediate safety. This requires a suicide risk assessment and ongoing safety plan with the client. Reference is to be made to the [NSW Health Framework for Suicide Risk Assessment and Management for NSW Health Staff](#). Following an assessment, an ongoing support plan must be activated with or on behalf of the client that explicitly addresses the concerns and may include contacting a mental health service, if applicable, and/or NSW Police if risk is acute, and providing 24 hour support numbers.

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<sup>16</sup> Typically this is a process by which the following information is used and integrated to determine risk: victim statements and narratives, particularly about the level of fear and self-assessment of risk; use of a tested actuarial risk assessment tool, which is appropriate to the expertise of workers expected to use the tool; professional judgement and practice wisdom drawn from workers' specialist knowledge of domestic and family violence to inform the process; and information gathered from other organisations, such as criminal records (Toivonen & Backhouse, 2018).



### ***Sibling sexual abuse***

When SASs are referred a child or young person who is living in the same house as a sibling who has engaged in PHSB, the SAS counsellor will undertake an assessment of the child's safety to continue with the intervention. This assessment will:

- focus on both protective and risk factors (Caffaro, 2014)
- be carried out in collaboration with any other relevant agencies involved (JCPRP, DCJ, New Street) in accordance with an agreed interagency plan concerning ongoing safety/support plans and different roles and responsibilities
- aim to determine whether there is sufficient safety for the victim to commence sexual assault counselling in respect to the proximity and living arrangements of the sibling; the family beliefs about the sexual abuse and its significance; and the immediate needs of the child or young person who has been sexually harmed
- consider a staged approach in relation to the living arrangements of the sibling. This will be determined in collaboration with the child or young person, family/carers and other relevant agencies. Ongoing monitoring of the safety strategies will occur.

Where an assessment indicates there is insufficient safety for counselling to commence, the SAS counsellor will communicate this and advocate for the changes required for the child to be safe.

The sibling who engaged in the PHSB, if under the age of 10, can also be seen at the SAS as long as any identified conflict of interest is resolved. Where the child or young person who harmed is over the age of 10, the most appropriate referral pathway is usually to New Street or, in situations where a New Street service is not available, an accredited private practitioner.

#### **13.5.2 Initial assessment**

All clients referred to, or who contact, SAS are to be provided with an initial psychosocial and safety assessment, which is sometimes also known as an intake assessment, prior to receiving any other SAS responses. The purpose of this initial assessment is to determine current safety and immediate and ongoing support and health care needs.

In practice, the nature, scope and timing of the initial assessment may vary depending on how recent the sexual assault was and whether or not the client is in crisis, as well as the specific operational arrangements of a SAS (e.g. if intake is provided by a SAS counsellor, both intake and initial assessment may be undertaken simultaneously, but if intake is provided by administrative staff, these may be two separate processes and initial assessment will be done as soon as possible after intake). Assessment is a dynamic process and the initial assessment will not always take place as one discreet event, especially following a recent sexual assault ([Section 14](#)) where intake, initial assessment, medical and forensic assessment, and interventions are likely to take place intermittently over the course of the crisis response service to the client.

The initial assessment will:

1. provide the victim with initial information about their rights and choices including:
  - a. the role of the SAS and services provided and its relationship to other agencies
  - b. confidentiality (including its limits), reporting obligations and the release of information about the client, including those processes requiring consent

- c. the legal process with regard to sexual assault (if appropriate)
2. establish immediate emotional, social, safety, health and legal needs
3. make referrals for other health (e.g. mental health), medical and/or forensic care and responses, if needed.

An initial assessment will include and document the following information in addition to what was gathered at intake, noting this is best done in a dynamic and collaborative way that maximises opportunities to prevent the client repeating information:

- confirmation and addition where necessary of personal and referral information recorded on intake ([Section 13.3](#))
- brief history in the client's own words of: the disclosure or discovery of the sexual assault, any information as to the type of sexual assault(s), date and time of the sexual assault(s), and client's relationship to the perpetrator(s)
- type and level of need of care or interventions including health, medical and forensic, counselling, information, and other support needs
- safety and child protection issues, including physical and psychological safety to self and others (e.g. relevant mental health or other medical history, self-harm or suicidal ideation, risk of further violence from perpetrator, and children at risk of harm)
- current emotional or physical concerns and impact of assault(s)
- whether the client wants a medical and forensic examination (where appropriate)
- resilience and support available, such as positive coping mechanisms, protective factors, and supportive family/significant others
- referrals, reports, interventions, current support provided, and communications from other professional/agencies including, but not limited to, NSW Police or JCPRP involvement
- plan for follow-up medical or psychosocial interventions (e.g. allocation to counsellor if urgent crisis response not required).

### **13.6 Priorities for client allocation**

Following an initial assessment, SAS will allocate clients to the appropriate service response. Priorities for allocation are to be based on the clinical assessment of safety and need identified in the initial assessment ([Section 13.5.2](#)). Factors to take into account when assessing priorities for client allocation based on clinical need may include, but are not limited to:

- safety (of client or others), vulnerability or child protection concerns
- severity of the impact of the assault or PHSB including the nature and impact of any negative coping strategies and whether the client is in crisis ([Section 14](#))
- the level of concern of the referrer
- resilience and supports available such as positive coping mechanisms, protective factors, and supportive family/significant others
- other professionals/support services involved, level of resources available to the client, and alternative referral options

- factors that may increase a person's vulnerability or increase their barriers to service access (e.g. Aboriginality, disability, cultural and linguistic diversity, LGBTQI status, age, extensive history of violence, geographic or social isolation, etc.).

In circumstances where safety and clinical need is assessed as approximately equal and there is a need to prioritise client allocation (e.g. due to insufficient resources), the priorities are:

1. people sexually assaulted within the past seven days (recent assault)
2. people sexually assaulted within the past 7-14 days
3. a child or young person under the age of 18 who has been sexually assaulted
4. a disclosure or identification of a child under 10 with PHSB, regardless of whether they have experienced sexual assault or sexual abuse
5. a belief following a clinical assessment that a child or young person and/or parents/carers would benefit from counselling or other SAS interventions ([Section 6.7](#))
6. adults sexually assaulted in the past year
7. any victims of sexual assault requiring court preparation and support, or cases where the sexual assault is the subject of any other type of investigation
8. adults sexually assaulted as adults more than one year ago
9. adults sexually assaulted as a child, taking into consideration their age on presentation

This priority order reflects that a recent experience or disclosure of sexual assault or identification of a child with PHSB is often a time of crisis for the client and their family/significant others; the importance of a timely and sensitive response to sexual assault and PHSB as a preventative measure in alleviating short and long term effects; and the value of SASs in assisting people who have experienced sexual assault to navigate the complex medico-legal systems that surround sexual assault.

Districts/networks will have referral procedures in place to appropriate trauma-informed or trauma-specific services where they are unable to provide a service response to a client who meets the SAS service criteria ([Section 13.1.1](#)) after the priorities for client allocation have been followed and the SAS has insufficient resources to respond. These procedures will include the provision of warm referrals and advocacy to support the person to access an alternative service response.

## 14 INTEGRATED SAS CRISIS RESPONSE (24 HOURS)

### 14 Integrated SAS crisis response (24 hours): summary

- There are three key elements of a SAS crisis response:
  1. coordinating the overall care commencing with an initial assessment
  2. providing crisis counselling, information, support, advocacy and referral
  3. providing medical and forensic services.
- An integrated crisis response is where a SAS counsellor and a medical and forensic examiner work in partnership to address the immediate psychosocial, emotional, and medical and forensic needs of person who has been sexually assaulted. The key focus of this intervention is the health, safety and wellbeing of the person who has been sexually assaulted.
- There are three main types of SAS crisis response to sexual assault:
  1. 24-hour integrated psychosocial, medical and forensic response for victims of recent sexual assault (past seven days).
  2. Priority SAS business hours integrated psychosocial and medical response for victims of sexual assault 7-14 days ago or any child victims of sexual assault (more than 14 days ago).
  3. Psychosocial only response for victims of sexual assault in the past (more than 14 days ago) who are in crisis as defined in this policy and procedures and their primary presenting issue is sexual assault.
- The district/network will provide appropriate dedicated rooms, attached to the ED, for this integrated crisis response to take place.
- A crisis response will usually commence within one hour of presentation and a medical or medical and forensic examination will commence within two hours of request.
- SAS staff will ensure appropriate follow-up and referral, including warm referral, for people who have experienced sexual assault.

The following section outlines the integrated psychosocial and medical and forensic crisis response services to be provided by SASs. The crisis response has three key elements:

1. coordinating the overall care of the person who has experienced sexual assault commencing with an initial assessment
2. providing crisis counselling, information, support, advocacy and referral
3. providing medical and forensic services.

The focus of this section is on the first two elements of the crisis response. Although this section touches briefly on the third element, medical and forensic services, in terms of how they intersect with other components of the integrated crisis response, detailed information about the provision of medical and forensic services is in [Section 15](#).

An integrated crisis response is where a SAS counsellor and a medical and forensic examiner work in partnership to address the immediate psychosocial, emotional and medical and forensic needs of person who has been sexually assaulted. In responding to sexual assault, NSW Health's

role is to focus on the emotional and physical health, safety and wellbeing of the person. While collecting forensic evidence is an important adjunct component of care for people who may want to pursue legal action, it is conducted as part of an integrated response where the physical, medical and emotional needs of the person who has been assaulted are prioritised. The district/network will provide appropriate designated rooms for SAS integrated crisis responses to take place. Details of the facilities and physical environments required for SAS, including for crisis response, are at [Section 23.2](#).

The timeliness of intervention is crucial to increasing the long term prospects of recovery (Burgess & Holmstrom, 1985; Bassuk 1980; Lievore, 2005; NSW Adult Sexual Assault Interagency Guidelines, 2006; CASA Forum, 2014; NASASV 2015; WHO, 2013a). A 24-hour integrated response will be offered to any person who has been sexually assaulted in the past seven days and a priority (business hours) integrated response will be offered to anyone sexually assaulted in the past 7-14 days and for children (under 16 years old) sexually assaulted at any time in the past. This priority response for people sexually assaulted in the past 7-14 days recognises that, while forensic time frames have passed, the person is likely to still be in an acute state of crisis and with emotional and medical needs to address. For children, disclosure is often a time of crisis regardless of how long ago the sexual assault occurred and there may be both medical needs and medical findings of relevance to a NSW Police or DCJ response.

A person who has been sexually assaulted may be in 'crisis' at any point in their recovery when triggered by certain events, regardless of how recent or long ago the sexual assault occurred. The decision to come forward and seek support for sexual assault may be very frightening, and may be experienced as a crisis in itself (NASASV, 2015). SASs will therefore provide a crisis assessment and 24-hour psychosocial only response, or support another health service to provide this, to a person who has been sexually assaulted and in crisis following a significant life event (as defined in Figure 12), when the primary presenting issue is sexual assault and regardless of when the assault/s took place. This is critical in assisting that person with their distress or circumstances and is often a critical point for initiating successful intervention. People who have experienced sexual assault and present in crisis but with a different primary presenting issue (e.g. acute mental health concerns) will be referred to the appropriate service for that issue. However, clear referral pathways are to exist and be provided for the daytime SAS.

SASs provide Aboriginal or Torres Strait Islander people with an urgent 24 hour psychosocial only response if they were sexually assaulted in the past and they present to the SAS in crisis seeking a response, even if not otherwise meeting the criteria for a crisis response. This is due to the historic and ongoing cumulative violence and trauma Aboriginal people and communities experience and the significant connection between violence, abuse, and neglect and colonisation and racism. It also recognises the high rates of suicide amongst Aboriginal people, as identified in The *NSW Suicide Prevention Strategy 2010-2015*, the [NSW Aboriginal Mental Health and Well Being Policy 2006-2010](#) and recommendations to NSW Health from the NSW Coroners Court.

Figure 12 outlines key types of crisis response presentations and responses provided by SASs.

Figure 12: Types of sexual assault crisis response presentations and SAS response

Type	SAS response	When provided
1. <b>Recent sexual assault, past 7 days.</b>	24-hour integrated psychosocial and medical OR 24-hour integrated psychosocial and medical and forensic (depending on victim's wishes).	Once the person has been triaged and medically and psychiatrically cleared by ED to see SAS.
2. <b>Sexual assault 7-14 days ago.</b>	Priority business hours integrated psychosocial and medical (medical optional depending on needs of client).	As soon as possible during business hours for the SAS.
3. <b>Sexual assault of a child (under 16 years) more than 14 days ago.</b>	Priority business hours integrated psychosocial and medical (and forensic if relevant).	At a mutually agreeable time negotiated between the child and family and SAS.
4. <b>Past sexual assault (more than 14 days ago)</b> where the person or their family presents to ED or SAS in crisis <sup>17</sup> following a recent first-time disclosure or discovery or a significant life event <sup>18</sup> where the primary presenting issue is sexual assault.	24-hour psychosocial* only response.  For Aboriginal and Torres Strait Islander people use Indigenous workers and/or consultation to ensure response is culturally safe ( <a href="#">Section 21</a> ).  *Where a SAS is co-located with other 24 hour psychosocial services (e.g. social work or mental health) this response may be provided by them. The SAS will provide professional support and consultation to help ensure these services are trauma-informed and have a good understanding of sexual assault. The SAS will also ensure there are clear and appropriate referral pathways into SAS business hours services and collaborative integrated practice with these services.	Once the person has been triaged and medically and psychiatrically cleared by ED.  Note that where a person does not present in crisis (and so doesn't qualify for a crisis response service), they will be referred to the SAS business hours service and provided contact details for the 24-hour phone and online counselling service at <a href="#">NSW Rape Crisis</a> .
5. <b>Past sexual assault of an Aboriginal and/or Torres Strait Islander person</b> who has presented to ED or SAS in crisis <sup>23</sup> where the primary presenting issue is sexual assault.		

<sup>17</sup> A crisis refers to a time of intense difficulty or danger.

<sup>18</sup> A significant life event is defined as: the birth of a child, the death of a loved one, the death of the person who abused them, seeing the person who abused them, high-risk domestic or family violence, homelessness, suicidal ideation or attempt, or recent sobriety or relapse with drugs and alcohol.



## **14.1 Sexual Assault Assessment Centres (SAACs)**

Those who live in rural and remote locations may experience increased barriers in accessing a timely integrated crisis response following a recent sexual assault. To address this, SAACs have been established in a variety of locations in rural and remote NSW. These locations were nominated as they are 200km from a Level 3 or Level 4 SAS ([Appendix 6](#)) where integrated sexual assault psychosocial and medical and forensic services are available.

The SAACs are designed to provide a vital link with the SASs that are providing an integrated crisis response. Trained counsellors working from the SAACs provide a 24-hour face-to-face response to anyone who has been sexually assaulted in the past seven days. SAAC counsellors provide crisis counselling and assessment and ensure the person is given all the information they need to make informed decisions about the course of action they wish to take. This is not only critical in informing their choices but also prevents clients having to undertake unnecessary travel to a facility for a medical and forensic examination that may be several hours away.

If assessed and agreed in consultation with the client and relevant SAS that referral to the on-call SAS is appropriate, the worker from the SAAC will coordinate this referral. The SAAC worker will organise transport for the person who has been sexually assaulted if they do not have someone who can drive them to the SAS. Prior to any travel commencing, a treating doctor from the local hospital must give clearance that the client is medically and psychiatrically fit to travel and the SAAC may consult with the SAS medical and forensic examiner to determine whether an Early Evidence Kit (EEK) may be appropriate ([Section 15.3](#)).

## **14.2 Providing a sexual assault crisis response**

The primary goal of a crisis response intervention to sexual assault is to decrease the long-term impacts of the sexual assault by providing a timely, comprehensive, and, in the case of more recent sexual assault, an integrated psychosocial, medical and forensic response. A person's physical and emotional health, safety and wellbeing is paramount and must be prioritised even when particular time frames exist in the gathering of forensic evidence for a NSW Police investigation.

In providing a crisis response, SAS will provide interventions that are client-centred and trauma and violence-informed, which means that they will:

- be respectful
- be non-judgmental
- be validating
- assist the person to regain their sense of dignity and control
- help access information and resources
- promote choice and control over actions taken
- increase safety
- support the person in reconnecting with themselves and to those who provide safe support.

The person who has been assaulted must be given enough time, and the information required, to make informed choices at a time when they may be psychologically overwhelmed.

It is the responsibility of the SAS counsellor to coordinate the crisis response and the overall care of the client. In this regard, the SAS counsellor plays a critical role by providing a coordinated response that aims to enhance the psychological and emotional safety and wellbeing of the person who has been sexually assaulted. Once a referral for a crisis response is received by a SAS counsellor, the counsellor is to commence an initial assessment ([Section 13.5.2](#)) as soon as possible and preferably within one hour of presentation. If the SAS counsellor cannot attend within the hour, the assessment may begin via telephone and be completed with a face-to-face interview.

If the district/network chooses, a SAS may employ the practice of the SAS counsellor and medical and forensic examiner attending a sexual assault crisis response jointly. Such practice helps to minimise the duplication of service and prevent the person telling their story multiple times. This practice will only take place where both the SAS counsellor and medical and forensic examiner can attend the service within one hour of the presentation (noting that medical and forensic examiners are usually required to attend within two hours of request). Where the SAS counsellor and the medical and forensic examiner attend the crisis response jointly, the initial crisis assessment will be the first priority and the client will be offered this without the medical and forensic examiner being present unless there are good reasons (e.g. related to safety) not to do so.

#### **14.2.1 Assessment and crisis counselling**

Crisis counselling is vital for someone who has been recently sexually assaulted or is in crisis for another reason (e.g. recent first disclosure, especially for a child). It is likely the person will be overwhelmed by the situation and the SAS counsellor must provide the emotional support required at this time, in addition to thoroughly assessing and responding to any concerns of the person who has been sexually assaulted.

The purpose of a prompt assessment and crisis counselling response is to:

- assess safety, social and emotional, legal and other needs, including referrals for other health, medical, or medical and forensic care and responses
- provide information — for example, about the nature of sexual assault, the legal system and reporting options, and services provided by the SAS
- assist in addressing trauma from the sexual assault and help prevent or mitigate any short or long-term health (including psychosocial) impacts
- help the person and their family/significant others address the crisis, which may include the trauma of disclosure
- assist family/significant others to provide appropriate support and care for the person who has been sexually assaulted
- provide practical support, including responding to safety, accommodation, transport and other needs.

The process of assessment and any resulting actions should increase knowledge, enhance safety, be empowering and promote choice, develop trust, and be mindful of the person's cultural

background. An initial assessment is to be undertaken during a crisis response in accordance with the guidance provided in [Section 13.5.2](#). The timing of the assessment will depend on the individual circumstances but is best done in a dynamic and collaborative way (with both the person who has experienced sexual assault and other workers) that maximises opportunities to prevent the client repeating information.

Following an initial assessment and in the course of the subsequent crisis interview and counselling response, the SAS counsellor will:

- Explain the role of the SAS. Explain it is their role to respond to the person's psychosocial needs and to coordinate their overall care. The coordination of care will take into account the preferences of the person who has been sexually assaulted, medical considerations (as discussed with the medical and forensic examiner), cultural safety, capacity to consent and safe work practices.
- Provide information about confidentiality and its limits, documentation of the crisis response and secure storage of SAS client files.
- Provide basic information about the medical and forensic process and examination and find out if the person who has been sexually assaulted would like to consult with, and/or be examined by, a medical and forensic examiner.
- Provide information about common responses to sexual assault and seek to make visible the coping mechanisms that the person has or is drawing upon to mitigate these impacts. This includes discussing self-care and their options for follow-up counselling in addition to enquiring about supportive people in the person's life who may be of help in this crisis.
- Provide information to family/significant others who may be key support people on how to support the person who has been sexually assaulted. This may include providing brief crisis counselling to a family member/significant other (this often takes place when the person who has been sexually assaulted is receiving a medical and forensic examination).

#### **14.2.1.1 Medical and forensic care during a crisis response**

It is the role of the SAS counsellor to consult with the medical and forensic examiner about the information obtained during the initial assessment and crisis counselling regarding the client's needs and wishes about a medical and forensic examination. The medical and forensic examiner will provide advice about whether a medical and forensic examination is possible or indicated based on the information provided, including consideration of the time elapsed since the sexual assault. [Section 15](#) provides detailed guidance on medical and forensic timeframes.

The SAS counsellor will contact the medical and forensic examiner as soon as possible to ensure minimal delay in providing a medical and forensic service. This will take place as soon as it has been established that a medical or medical and forensic examination is desired by the person who has been sexually assaulted. The medical and forensic examination is to commence within two hours of the request by the SAS counsellor (if the service is not operating a joint call-out model as described in [Section 14.2](#)).

If the examination cannot commence within this time frame because the medical and forensic examiner is not available, the person who has been sexually assaulted will not arrive at the SAS from another NSW Health facility in that time, or it is unsuitable for the patient either due to intoxication or other health issues, the medical and forensic examiner will discuss options to

facilitate client comfort and the retention of any forensic evidence. This may include the use of an EEK ([Section 15.3](#)) to help preserve evidence while enabling care and comfort (e.g. being able to eat/drink and go to the toilet) of the person who has been sexually assaulted. If a person's judgement or ability to consent is impaired, for example, due to drug or alcohol use, the medical and forensic examiner should be guided by the ED physician.

#### **14.2.2 Coordinated and collaborative care during a crisis response**

On the arrival of the medical and forensic examiner, the SAS counsellor will provide the examiner with a summary of the context of the presentation and any matters of psychosocial and medical or forensic relevance identified thus far. The SAS counsellor and the medical and forensic examiner will discuss how to collaboratively manage the coordinated care of the client. While the SAS counsellor is responsible for coordinating the overall crisis response, the medical and forensic examiner is responsible for coordinating the medical and forensic components of care and will provide input into case planning.

The SAS counsellor will be present and promote client comfort and advocate for their needs during the medical and forensic consultation. The role of the SAS counsellor at this time is to: provide validation and reassurance, advocacy, assist the client to manage their emotions, provide practical care, and, if required, clarify information conveyed by the medical and forensic examiner. During this process, the medical and forensic examiner will determine whether a client wishes to proceed with, and is able to provide valid consent for, a medical or medical and forensic examination. It is the role of the medical and forensic examiner to gain the informed and valid consent of any person who wishes to proceed ([Section 15.6](#)). No examination is to be provided unless a person is able and willing to proceed.

#### **14.2.3 Support person**

A person who has been sexually assaulted will be given, where possible, the option of having a person they consider supportive present during the crisis response. Consideration will be given to whether this person may be called to be a witness in a criminal trial, and whether the person who has experienced sexual assault or their support person may have any concerns about this so that they can make an informed decision. It is preferable that a person who was a witness to the assault, or was the first person the patient disclosed the assault to, does not act as a support person. However, the preferences and psychological needs of the patient must be taken into consideration.

When the patient is able to independently communicate their wishes (even where they can't legally consent), they will be given an opportunity to spend some time with the medical and forensic examiner and/or SAS counsellor without their support person. This allows i) for specific inquiry as to whether the patient has anything additional to disclose in confidence, and ii) for the SAS staff to confirm that the patient wishes their support person to be present.

The patient may ask the support person to step out for any particular part of the SAS response (for example, the physical examination).

In addition to considering a support person of their choosing, Aboriginal clients will be offered an Aboriginal Health Worker, if available, to help navigate and better understand the processes involved in the SAS crisis response.

### ***Potential impact on the support person***

Support persons can be affected by hearing the nature of the sexual assault and/or its impact on the person they are supporting. Potential impacts include: emotional and psychological trauma; exhaustion; and triggering of the support person's own history of trauma. SASs will:

- Ensure they observe trauma-informed practice ([Appendix 4](#)) in relation to all people attending the SAS.
- Seek the support person's verbal consent to being present.
- Offer support persons the opportunity to decline to be present, particularly during the discussion of traumatic events or physical examination.

More information about a support person and 'chaperones', specifically for medical or medical and forensic examinations is at Sections [15.8.9](#) and [15.8.11](#).

### **14.2.4 Crisis response considerations for certain groups**

#### ***Young person aged 14-16***

Young people aged 14-16 years who have been sexually assaulted may be seen by either a child or adult SAS. This decision is made on a case-by-case basis and with the best interest of the young person in mind. If a young person presents to an adult service first they will usually be seen by the adult service.

The following are to be considered when deciding whether a child or adult SAS (where they are different services) is most appropriate to meet the emotional, and medical and forensic, needs of this age group:

- some young people are more physically, sexually and emotionally mature and therefore an adult setting may be more appropriate to discuss emergency and ongoing contraception and managing the risks of sexually transmitted infections
- the expertise of the medical and forensic examiner (paediatric or adult)
- the context of the abuse. That is, the sexual assault of a young person by an acquaintance or a partner may be more appropriately seen by an adult service whereas a young person sexually assaulted by a family member or sibling may be more appropriately responded to by a child SAS.

While it is possible for a young person aged 14 years and over to consent to a medical and forensic examination on their own behalf where they understand the nature and consequences of the examination, it is good practice to involve the non-offending parent or legal guardian in the consent process if possible and where appropriate. It is also good practice to involve the parents or carer of the young person in the crisis psychosocial assessment and ongoing support, unless safety is a concern.

#### ***Drug facilitated sexual assault (DFSA)***

DFSA refers to sexual assault that occurs while a person is under the influence of drugs or alcohol. The DFSA may be opportunistic (where the person voluntarily ingested the drug) or proactive, where the person was the victim of deliberate 'spiking', with both circumstances resulting in



impaired capacity to consent to sexual intercourse or activity. Most people who suspect that they have been the victim of DFSA and who present to a SAS often do so some time after the sexual assault. Some have clear memories of what took place, but many don't.

Where DFSA is suspected, testing to maximise the chances of detecting these substances is to be administered in a timely fashion. The decision to offer a test remains a clinical decision by the medical and forensic examiner (see [Section 15.4](#)).

In most circumstances, a SAS cannot categorically state that a person who fears that they have been the victim of DFSA has in fact been sexually assaulted. The SAS counsellor will in conducting their crisis interview and counselling response pay particular attention to emotional distress that 'not knowing' can raise for a person. The SAS counsellor will consult with the medical and forensic examiner about whether a medical or a medical and forensic examination is appropriate if the client indicates they are interested in these options.

### ***People with multiple crisis presentations to ED***

SASs will put in place case management plans to address the needs and issues of clients known to the SAS with multiple crisis presentations to ED after hours. These plans must involve an assessment and consideration of the client's presenting issues, vulnerability and safety on each presentation. They will also include follow-up support arrangements with the SAS.

## **14.3 Concluding a crisis response**

At the conclusion of the integrated crisis response, it is essential that the person and their support people are given as much information as possible, including follow-up options.

### **14.3.1 Addressing psychosocial or safety needs**

In concluding the integrated crisis response, it is important that any relevant psychosocial issues, including safety and risk of harm (self-harm, suicidal ideation and child protection) concerns be addressed and that follow-up psychosocial care (e.g. follow-up counselling options) is offered. The SAS counsellor will also address any other concerns and needs that the person may have, including support to find safe accommodation. Follow up actions by the SAS counsellor, including follow-up counselling by the SAS and/or referral to other services, will be agreed upon with the person who has been sexually assaulted.

The SAS counsellor will provide the person who has been sexually assaulted with information about common responses to sexual assault, the contact and location details of the SAS and services they provide, and crisis lines available e.g. [NSW Rape Crisis](#).

### **14.3.2 Addressing medical needs**

Following a medical or medical and forensic examination, the medical and forensic examiner will discuss any findings with the patient and their parent/caregiver/significant other, if appropriate and with the appropriate consents. The medical and forensic examiner will allow sufficient time to deal with any concerns that arise. These findings might also be discussed with the SAS counsellor and/or police after obtaining the appropriate consent. The medical and forensic examiner will also provide information about the storage and destruction of the Sexual Assault Investigation Kit (SAIK) if the person who has been sexually assaulted is an adult ([Section 15.12](#)).



### **14.3.3 Criminal justice system information**

The SAS counsellor will, if they haven't already done so, provide the person with information about the role of NSW Police and the legal system. This includes providing relevant information about reporting options and discussing the possible implications of these. Each person who has experienced sexual assault will be given a copy of the Charter of Victims Rights and information about NSW Department of Justice, Victims Services. If the person who has been sexually assaulted requests with the appropriate consents in place, the SAS counsellor may also liaise with NSW Police for further clarification or assistance.

### **14.3.4 Documentation of the psychosocial components of a crisis response**

All details of the SAS crisis response, including initial assessment, treatment and planned follow-up will be documented in the record documentation system stipulated by the district/network in a way that reflects NSW Health policy. It is of critical importance that client records are both accurate and comprehensive, as they provide a record of the reporting of a sexual assault, the immediate impact, any intervention that took place and any follow-up actions that are agreed upon. Files will be stored in accordance with SAS requirements and in accordance with [Health Care Records — Documentation and Management \(Section 22.1\)](#). Information about medical and forensic records is at [Section 15.14](#).

## **14.4 Follow-up care and referral**

Follow-up care is a critical aspect of a crisis response. SASs will have a procedure that ensures active follow-up, which is communicated to the client at first contact, including asking the person whether it is ok if the SAS calls them the next day (or next business day) to check how they are.

It is common that many people in the crisis period wish to avoid thinking and talking about what occurred and it is common that denial, fear and shame prevent some people from attending the SAS for follow-up treatment and support. Active follow-up by the SAS following a crisis response is therefore essential. Where possible, it is best practice for active follow-up to involve the same SAS counsellor who provided the crisis response, if available, in recognition of the importance of building on the development and support of a trusting therapeutic relationship. During the crisis response, some people who have been sexually assaulted indicate that they do not want ongoing support from the SAS. Where this is communicated, it will be respected by the SAS and documented in their file.

Active follow-up includes contacting clients after first or subsequent missed follow-up appointments, unless the client has expressed a clear wish not to be followed up.

The SAS counsellor will advocate on behalf of the person who has been sexually assaulted and their family/significant others by providing information and warm referrals where possible to other relevant services and supports as required and agreed upon during the crisis response.

The medical and forensic examiner will discuss and provide follow-up medical appointments or referrals — for example, regarding injuries, pregnancy, sexually transmissible infections and other general medical matters — to a person who has been sexually assaulted (as appropriate) ([Section 15.9](#)). Where these services are provided by the SAS, they will be conducted in a private and sensitive manner.

#### **14.4.1 Transfer of follow-up care to another SAS**

People who live outside the SAS's catchment area are to receive an active follow-up psychosocial and medical and forensic response (where appropriate) by their local SAS if they choose to. This may require liaison, with the relevant consents, between the SAS who provided the crisis response and the SAS being referred to, relevant JCPRP senior health clinicians/health clinicians (where a child or children are involved), and other agencies or health organisations. Local procedures are to be in place to facilitate a timely and appropriate 'warm referral' (both a verbal and written referral and summary of care handover by the relevant SAS staff) from one SAS to the other. Where interstate services are involved, the SAS will liaise with these services as required in accordance with the relevant cross-border protocols.

#### **14.5 Discharge from ED**

Once all components of the SAS crisis response intervention are complete, SAS staff will arrange for the person who was sexually assaulted to either:

1. return to the ED if any immediate follow-up medical or psychiatric treatment is required, and, in doing so, arrange an appropriate handover with clinical information relevant to further treatment to relevant staff (verbal and in the medical record as required), OR
2. be discharged from ED.

In addition to recording any information of clinical relevance as noted above, SAS staff will document in the ED medical record as appropriate:

- 'SAS response provided and patient returned to ED to the care of [note relevant doctor/nurse] for further treatment', OR
- 'SAS response provided and patient to be discharged by ED'.

## 15 MEDICAL AND FORENSIC ASSESSMENT AND MANAGEMENT

### 15 Medical and forensic assessment and management (24 hours): summary

- SASs provide medical or medical and forensic assessment and management to victims of sexual assault as part of an integrated psychosocial and medical and forensic response.
- SASs will offer people who have experienced recent sexual assault (within the past seven days) a 24-hour integrated psychosocial and medical or medical and forensic response. SASs will offer adults who have experienced sexual assault in the past 7-14 days and children who have experienced sexual assault at any time a priority business hours integrated psychosocial and medical response. ([Section 14.](#))
- There are specific roles and responsibilities for medical and forensic examiners, districts/networks and medical leads concerning medical and forensic responses to sexual assault ([Section 15.1](#)).
- The provision of urgent medical treatment, including psychiatric care (in the case of acute mental illness), takes priority over a sexual assault medical or medical and forensic examination ([Section 15.2](#)).
- An Early Evidence Kit (EEK) is to be considered in all cases where a medical and forensic examination is unavoidably delayed ([Section 15.3](#)).
- Medical and forensic examiners and SAS counsellors will consult each other regarding psychosocial and medical assessment of the patient and together plan the integrated response before a medical and forensic consultation ([Section 15.5](#)).
- Medical and forensic examiners will seek the appropriate consent for conducting an examination and releasing information (Sections [15.6](#) and [15.7](#)).
- There are a number of considerations and requirements for the provision of a medical or medical and forensic consultation ([Section 15.8](#)). These include using a Medical and Forensic Examination Record (MFER) and Sexual Assault Investigation Kit (SAIK) when conducting a medical and forensic examination.
- Follow-up medical care will be offered by the district/network where possible or through appropriate referrals (Sections [15.9](#) and [15.10](#)).
- SASs will follow the relevant procedures for the packaging, storage and destruction of SAIKs (Sections [15.11](#) and [15.12](#)).
- Medical and forensic examiners will follow the relevant policies and procedures, including for secondary employment and use of NSW Health facilities and equipment, when taking samples from a person of interest or undertaking activities for the defence (Sections [15.13](#) and [15.14.4](#)).
- SASs will follow the relevant policies and procedures related to medical records and medico-legal report writing, including Expert Certificates ([Section 15.14](#)).

This section details the medical and forensic assessment and management provided to victims of sexual assault. It is provided as a standalone section for ease of reference for medical and forensic examiners. However, it is best to also be read in conjunction with [Section 14](#) on crisis responses to understand how medical and forensic services are a key part of an integrated psychosocial and medical and forensic response to sexual assault.

Medical and forensic examinations in NSW are provided in a health context (rather than a justice context) to maximise the therapeutic benefit and minimise disruption and re-traumatisation of the patient. This reflects the scope of functions local health districts and specialty networks, as provided by the [Health Services Act 1997](#) as well as international best practice.

Forensic services take place within a broader context of more general health care, such as treating injuries, responding to the patient's medical concerns about the sexual assault and managing sexually transmitted infections. Forensic examinations must therefore be integrated with healthcare provision, to optimise health and wellbeing outcomes. Where it is clinically safe to do so, health care and forensic elements will be offered at the same time, in the same location and by the same health professional. These services are also to be offered in such a way as to minimise the number of invasive interviews and examinations clients are required to undergo.

## **15.1 Roles and responsibilities**

### **15.1.1 Qualifications and training of medical and forensic examiners**

A medical and forensic examiner can be either a medical officer or a sexual assault nurse examiner (SANE), noting that SANEs can only provide services to people 14 years and over. A medical and forensic examiner must have been credentialed<sup>19</sup> by their district/network as being capable of independently performing the roles described in this document before they can work without supervision.

The following are minimum requirements for qualifications and training for medical and forensic examiners. Districts and networks may determine additional entry requirements, qualifications, training and competencies for medical and forensic examiners as part of their local employment and credentialing process.

#### ***Medical officers***

It is best practice for medical officers treating patients who have been sexually assaulted to have postgraduate qualifications or training in the management of sexual assault.

#### ***SANEs***

A SANE must at a minimum be registered as a nurse practitioner with the Nurses and Midwifery Board or be registered as a nurse with the board and have a minimum of three years clinical nursing experience in a relevant clinical speciality such as sexual health, family planning, women's health, obstetrics and gynaecology and emergency medicine).

SANEs must have obtained, or be working towards, the [ECAV](#) Graduate Certificate in the Medical and Forensic Management of Adult Sexual Assault or Monash University's Graduate Certificate of

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<sup>19</sup> The credentialing process is undertaken by each district/network and determines the scope of practice of the clinician.

Forensic Medicine (or equivalent as determined by the local credentialing process). If the latter, the Certificate must include the Adult Sexual Assault unit.

Before they can work independently, a SANE must have:

1. been awarded one of the graduate certificates identified above (or equivalent)
2. provided a minimum of 3 crisis responses where their clinical practice is directly supervised<sup>20</sup> (or shadowed) by an experienced medical and forensic examiner
3. indirect supervision<sup>21</sup> for each and every case when deemed appropriate by their supervisor to practice without direct supervision, until credentialed.

### **15.1.2 Role of medical and forensic examiners**

Medical and forensic examiners will:

- Offer a medical or medical and forensic consultation<sup>22</sup> in a timely manner to
  - adults, young people and children who have recently been sexually assaulted
  - adults presenting with concerns about possible recent sexual assault ([Section 15.5](#)),
  - (where clinically appropriate) families with concerns about possible child sexual assault.

Note: medical and forensic examiners can provide services to children only if appropriately credentialed — some examiners will be credentialed only to see children, some only to see adults and young people, and some both.

- Provide quality medical care; and ensure the best possible forensic evidence is obtained to support the justice process.
- Perform a medical or medical and forensic examination<sup>23</sup> with the appropriate consent and provide or arrange continuing medical care when necessary.
- Provide trauma-specific, integrated, holistic and culturally safe care.
- Work with a multidisciplinary SAS.<sup>24</sup>
- Provide timely court reports and expert certificates when requested by the SAS.

<sup>20</sup> This 'direct supervision' may be in person or via video-linked telehealth. The minimum number of direct supervision cases required (i.e. 3 or more) will be determined by the supervisor taking into account the nurse's previous relevant experience and demonstrated competence.

<sup>21</sup> 'Indirect supervision' will include the availability of phone support until suitably skilled and experienced as well as case review, supervision, debriefing, review of expert certificates, and other quality assurance activities for every case. Note, while these are normal quality assurance activities for all medical and forensic examiners, these would usually be provided ad hoc for experienced medical and forensic examiners and not for every case.

<sup>22</sup> A medical and forensic consultation is a broad term that covers the whole process of a medical and forensic intervention with a sexual assault patient; from consent through to taking a history, the medical and forensic examination, treatment, and arranging follow up.

<sup>23</sup> In NSW Health, a general medical examination (see glossary) may be provided without a forensic examination (see glossary), however a forensic examination must be accompanied by a general medical examination. The term 'medical and forensic examination' is therefore used here to mean either a medical examination or a medical and forensic examination of a victim of sexual assault unless otherwise specified.

<sup>24</sup> As noted in Section 1 SAS used here refers SASs, Child Protection Units and integrated violence, abuse and neglect (VAN) services that include within their responsibilities primary responsibility for responding to sexual assault.

- Testify in court when subpoenaed.
- Participate in training, continuing professional development, and other skill development activities related to their role with the SAS.
- Participate in quality assurance processes, such as regular peer review, performance appraisal in accordance with contract or award conditions as relevant, clinical supervision, debriefing and staff meetings, as well as in research where appropriate.
- Participate in training, continuing professional development, and other skill development activities related to their role with the SAS.
- Participate in quality assurance processes, such as regular peer review, performance appraisal in accordance with contract or award conditions as relevant, clinical supervision, debriefing and staff meetings, as well as in research where appropriate.

### **15.1.3 Responsibilities of districts/networks**

Districts/networks will:

- Employ medical and forensic examiners to provide medical and forensic services to individuals who have experienced sexual assault. For patients 14 years and over, this may be by a credentialed Medical Officer or by a credentialed SANE. For children aged up to 14 years of age, this must be by a specifically credentialed medical officer.
- Appoint a designated medical director with responsibility for the overall coordination and quality assurance of the medical and forensic component of the district/network's response to sexual assault. The medical director will work in accordance with the principles outlined in this document and in conjunction with the SAS manager or clinical lead. A district/network may appoint a SANE to provide overall coordination and management of the medical and forensic response to sexual assault, but, in such circumstances, a medical director will still be identified to provide medical mentoring and support for that SANE. Where it is not possible at this time to appoint a medical director from within the district/network for this purpose, a doctor with the appropriate clinical skill may be contracted from outside of the district/network to provide this function.
- Provide medical and forensic examiners with access to regular supervision from a suitably qualified and experienced medical and forensic examiner. In this context, supervision is a: "relationship based activity which enables practitioners to reflect upon the connection between task and process within their work. It provides a supportive, administrative and development context within which responsiveness to clients and accountable decision-making can be sustained" (Davis, 2000, p. 200, cited in HETI, 2012, p. 6).
- Have induction processes for new staff, including staff employed purely after hours.
- Facilitate the participation of medical and forensic examiners in regular peer review processes, staff meetings and continuing professional development.
- Ensure the SAS manager or their delegate (rather than the medical director) coordinates the psychosocial and medical responses to individual acute presentations, with appropriate medical input into case planning.



- Have processes in place outlining the local response to child sexual assault, including access to the Child Abuse and Sexual Assault Clinical Advice Line (CASACAL)<sup>25</sup> for expert clinical advice and support.

#### **15.1.4 Role of the medical director**

The role of medical director will be filled by a doctor and will provide the overall coordination and quality assurance of the medical and forensic components of the district/network's response to sexual assault. The medical director will be credentialed as a medical and forensic examiner and will ideally also have management experience.

The responsibilities of the medical director include (but are not limited to):

- ensuring, in collaboration with the SAS manager or clinical lead, the integration of trauma-specific, psychosocial and medical and forensic responses to sexual assault is working in the best interests of the client.
- organisation and delivery of quality medical and forensic services, including recruitment of medical and forensic examiners, ensuring adequate staff availability to provide 24-hour services, and performance management and review of medical and forensic examiners
- developing local procedures for medical and forensic responses to sexual assault, including current and regularly updated clinical guidelines (e.g. covering STI testing for victims of sexual assault, access to medical test results, forensic decontamination protocols)
- facilitating appropriate training and continuing professional development for medical and forensic examiners, including those who work after-hours only
- facilitate the participation of medical and forensic examiners in regular peer review processes, clinical supervision, debriefing, and staff meetings related to their SAS role
- ensure appropriate debriefing and clinical supervision of SAS medical and forensic examiners, including those who work on-call
- monitoring of quality assurance for medical and forensic responses to sexual assault
- promotion of the CASACAL service to ensure access to timely clinical advice for child and adolescent sexual assault matters for Local Health District medical and forensic examiners.

Some or all of these responsibilities may be delegated to a credentialed SANE in the district/network. However a medical director must still be identified to provide medical mentoring and support for that SANE.

### **15.2 Care of patients who sustained injuries during a sexual assault**

The provision of urgent medical treatment, including psychiatric care (in the case of acute mental illness), takes priority over a sexual assault medical or medical and forensic examination. Where it is medically and professionally appropriate, these processes can occur together (for example, where a patient requires urgent bladder catheterisation and it is possible to obtain genital swabs during this process and consent is obtained).

<sup>25</sup> CASACAL refers to the NSW Health Child Abuse and Sexual Assault Advice Line which provides expert advice and support to doctors and nurses providing medical and forensic examinations and medical care to children and young people (up to their 16th birthday), who are suspected victims of sexual assault, physical abuse or neglect.

Victims of recent sexual assault (past seven days) are to be triaged and assessed by medical staff as stable enough to be referred or transported (where appropriate) to a SAS ([Section 14](#)).

Minor injuries incurred during the sexual assault can be attended to as part of the medical and forensic examination. Medical and forensic examiners are not expected to treat serious medical conditions (such as strangulation) unless these are within their scope of practice (e.g. recent ED experience) and it is safe to do so.

Patients may have experienced strangulation as part of their assault or during recent domestic and family violence. The district/network will do the following:

- Screen patients for strangulation both at triage in the ED and in the SAS and provide those patients who screen positive with an appropriate medical assessment. This is because non-fatal strangulation carries a risk of serious injury (e.g. carotid artery dissection) and is an important risk factor for homicide for women.
- For patients referred to the SAS by an ED who later screen positive for strangulation, pathways are to be in place to identify which patients will be referred back to the ED for further medical assessment.
- For patients referred to the SAS from an inpatient health service (including inpatient mental health services), who later screen positive for strangulation, a referral pathway will be provided for further medical/surgical assessment for the strangulation.
- When children or young people disclose they were 'grabbed' by the neck or any words to that effect, at any time during an incident of child sexual or physical abuse, consider strangulation injuries and whether to consult with CASACAL, after local advice and escalation pathways have been followed, to assist with assessment of possible internal and external injury.

### ***Age related considerations***

Staff caring for children in particular where there are concerns about sexual abuse often worry that medical and nursing care may adversely affect the investigative process. However, potentially serious medical problems — such as vaginal bleeding — must always be assessed and treated promptly. The SAS can provide advice about how to do this in a way that minimises evidence loss or contamination and is to be consulted as early as possible.

Clinicians in EDs may also access CASACAL for advice.

## **15.3 Early Evidence Kits (EEKs)**

Early Evidence Kits (EEKs) will be offered where a medical and forensic examination is unavoidably delayed, or if a patient needs to urgently eat, drink, shower or pass urine or a bowel motion before a medical and forensic consultation.

EEKs provide an opportunity for collection of evidence in circumstances where evidence may otherwise be lost, and enhance patient comfort. An EEK does not replace a medical and forensic examination and is to be followed (with patient consent) by one.

The EEK Clinical Guideline is in draft. The clinical guideline will support EEK provision to children, young people and adults able to self-collect samples within a guided collection process. EEKs will

be held at NSW Health facilities until released to NSW Police or destroyed. A consent form will be included in the EEK for children and young people 15 years old and under, as EEKs for this patient group will be automatically released to NSW Police. For people 16 and over, a consent form is not required to provide an EEK as the samples are self-collected. People 16 and over will complete a consent form after the EEK is taken to either release to NSW Police or be destroyed.

These policy and procedures will be updated when the EEK Clinical Guideline is released, with an accompanying information bulletin. Until this time the following applies:

- Collection is to be documented with the date/time and specimen identifier number.
- Samples are to be sealed in a tamper-proof bag and stored in a locked box in a fridge or a locked fridge or freezer.
- If EEKs are deployed in facilities that do not have a SAS onsite (prior to potential transfer of the patient to the facility with a SAS), the EEK is to remain at the initial facility and not be released to NSW Police without a search warrant or discussion with the relevant SAS. If the SAS is onsite, they will take responsibility for maintaining the chain of evidence once they have engaged with the patient.
- Patients who have an EEK are to be offered a medical and forensic examination (including a Sexual Assault Investigation Kit (SAIK)) if appropriate but are not obliged to take this up.
- EEKs will be kept for seven days, and will be destroyed unless further instructions are provided. These instructions will be either consent to release the EEK to NSW Police or temporary hospital storage for three months. This seven day time period can be lengthened in extenuating circumstances. The discussion with the patient about specific consent to release/temporary hospital storage can be in person or by phone. Signed consent is preferred, but verbal consent is acceptable where the consent has been heard by two NSW Health workers (this may be a SAS counsellor or medical and forensic examiner), steps have been taken to verify the caller's identity, and the process and results have been documented in the client file.
- To reduce handling of samples, EEKs are not to be opened and placed inside the SAIK. The SAIK envelope is to be updated with the EEK identifying number, and if the SAIK and EEK are stored separately, the front of the EEK evidence bag is to be updated with the SAIK number.

### ***Age-related considerations***

EEKs completed by children and young people 15 years and under are automatically released to NSW Police, and temporary hospital storage is not an option. For this reason, an EEK is not to be collected from a child 15 years and under unless the child and/or their parent/carers is fully aware that the samples, once collected, will be released to NSW Police. A robust process must be in place to ensure children 14-16 make an informed choice to take an EEK, and that parents/carers for children under 14 years make an informed choice to allow their child to take an EEK. When

considering the collection of an EEK from a child, consider contacting CASACAL if unsure of when and how to use an EEK after following normal local consultation processes.

#### **15.4 Management of suspected drug or alcohol facilitated sexual assault (DFSA)**

DFSA refers to sexual assault that occurs while the patient is under the influence of a stupefying drug. The patient may have voluntarily ingested a drug that has impaired their ability to consent to sexual intercourse or another person may have deliberately added alcohol or another drug to their food/drink (aka 'drink spiking') or administered drugs through another route.

The ability to detect drugs and/or alcohol through toxicology screening diminishes rapidly over time. Districts/networks will therefore facilitate the collection of urine and blood samples by the medical service to which the patient disclosed the assault (e.g. the ED or mental health unit) as early as possible and in a trauma-informed manner.

A Tox Kit NSW Police or a Traffic Accident Blood and Urine Kit can be used by ED or mental health nursing or medical staff. The kit is to be appropriately sealed and stored following the same procedures used to handle EEKs ([Section 15.3](#)) and the collection documented with the date/time of collection, specimen identifier number, and collector's name.

If the medical and forensic examiner later determines that the samples are not required, or the patient does not consent to the inclusion of the samples in a SAIK, or if the patient does not have a consultation with a SAS counsellor or medical and forensic examiner about the disposition of the samples within seven days, the samples will be destroyed.

Some medical and forensic examiners may offer the patient the option of toxicology testing using a non-forensic Health pathway; note, the results are unlikely to be admissible in court, although they may provide the patient with helpful information. Options include non-forensic testing via FASS, which will provide results similar to those from a forensic pathway, or testing in local hospital laboratories, which requires the examiner to have a thorough knowledge of what drugs can be tested for in the laboratory in question, the ability of each test to detect trace amounts of the drug, and the false negative and positive rates of the individual tests. Regardless of the option chosen, the SAS will need to have a reliable pathway for checking and actioning the results.

#### ***Age-related considerations***

When considering toxicology testing for children under 16 years, medical staff and medical and forensic examiners are able to contact CASACAL for advice.

Toxicology samples from children under the age of 16 years cannot be destroyed and must be handed over to Police.

#### **15.5 Consultation, information gathering and initial case planning**

Medical and forensic examiners and SAS counsellors will consult each other regarding the psychosocial and medical assessment of the patient and together plan the integrated response prior to the medical and forensic consultation. More detail about the process for an integrated psychosocial and medical and forensic crisis response to sexual assault is in [Section 14](#).

As noted in Section [14.2.1.1](#), the SAS counsellor will contact the medical and forensic examiner as soon as it has been established that a medical and/or a medical and forensic examination is desired by the patient (unless the district/network uses a joint callout model — see [Section 14.2](#)). The medical and forensic examiner will arrive at the SAS within two hours of request by the SAS counsellor. The medical and forensic examiner will ordinarily attend even if the patient has indicated to the SAS counsellor they desire a medical examination only because:

- Trauma-informed practice and good patient care requires that the patient receives medical care from a clinician with specialised training in responding to sexual assault.
- Patients referred back to the ED for a medical response following a sexual assault are unlikely to receive a timely response given competing priorities.
- Many patients who initially indicate they only wish to have a medical consultation change their mind once they have met and feel at ease with the medical and forensic examiner and go on to have a full medical and forensic consultation.
- Many clients disclose further abuse once they have met the examiner.

Where the patient has provided clear advice that they only wish to have a limited medical response (e.g. access to emergency contraception or HIV post-exposure prophylaxis) and the ED is able to provide a timely response, it may be more appropriate to refer them back to the ED to meet these needs.

If the examination cannot commence within two hours of request, the medical and forensic examiner will discuss options to facilitate client comfort and the retention of any forensic evidence, including the use of an EEK ([Section 15.3](#)).

Where it is practical to do so, and where consent allows, the medical and forensic examiner and SAS counsellor are to consult NSW Police regarding the timing and nature of the sexual assault, the role of a medical and forensic examination, and potential evidence collection.

Each SAS will ensure that current NSW Police *Guidelines for the collection of forensic specimens from complainants and suspects* are available to medical and forensic examiners in the location where the medical and forensic examination takes place.

If the SAS counsellor attends before the doctor, they will provide the following information, if available, to assist the medical and forensic examiner in planning a timely examination:

1. the date(s)/time(s) of the sexual assault(s)
2. whether the assault involved the mouth or ano-genital area
3. a history of possible intoxication or current symptoms suggestive of intoxication or other drug use
4. information from triage (for example, vital signs, significant injuries, history of strangulation or head injury, pain)
5. whether an interpreter may be required
6. issues relevant to the patient's capacity to consent, if present (for example, intoxication, intellectual impairment, distress or the presence of a serious mental illness/disorder)

7. issues relevant to the patient's immediate medical needs and capacity to consent, including mental health care needs, if present
8. current location of the patient
9. whether the patient wants a forensic examination (if known)
10. presence of any memory loss
11. whether an interpreter is required
12. whether the patient is Aboriginal

Note: The preceding section does not apply to services where the SAS counsellor and medical and forensic examiner jointly present after a referral (See [Section 14.2](#)).

When a patient presents with a concern about possible recent sexual assault but without a clear memory of the event, the SAS will adopt a supportive, respectful approach and address the person's concerns and emotional state. The SAS does not have a role in determining if an assault has, or has not, occurred — this is a matter for NSW Police. The SAS will offer a crisis response in accordance with [Section 14](#) and following local procedures. In most circumstances, this will involve an integrated psychosocial and medical response. The medical and forensic examiner will be informed of the circumstances, either when the patient first presents or after the SAS counsellor has assessed the client, as per [Section 14](#) and local procedures. The patient's immediate medical needs are to be identified and met in the most time-efficient way. A medical and forensic examination or an EEK may be provided if appropriate and where the patient provides informed consent.

If the patient has an impaired ability to give a full history because of a concurrent medical condition (for example, from a head injury, intoxication or mental disorder) or is unconscious, and there are concerns about possible sexual assault, refer to [Section 15.6](#) below as is appropriate for the specific circumstances.

### ***Age-related considerations***

For matters involving children under 16 years old, the medical and forensic examiner will need sufficient information to decide whether an examination is warranted, how urgent it is and when, as well as information about any factors that may impact the examination (for example, who can provide consent for the examination).

Information that could be pertinent for this decision-making process, if it can be provided in a timely manner, may include the following:

- the provision of information by the JRU on a Health Service for Action Form
- the reason the JCPRP or other referring agency is requesting the medical and forensic consultation (e.g. collection of forensic samples, checking for injuries, assessment of sexually transmissible infection risk, allaying the anxiety of the child and family)
- whether the child or young person has participated in a JCPRP investigative interview and what, if any, disclosures were made
- the nature of the sexual assault (for example, what part of the child's body was penetrated and how)



- when the assault occurred
- how the disclosure occurred. If the child disclosed in words, what did the child actually say, and to whom? If an adult witnessed it, what did they actually see?
- whether the child has current medical complaints/symptoms that may be related to a sexual assault (for example, genital or anal bleeding, dysuria, pain)
- any other relevant medical information (for example, developmental delay, past history of red genitals)
- the current emotional state of the child and how tired or sleepy they are
- any urgent social information concerning family dynamics
- any other relevant social information
- whether a trusted non-offending adult can accompany the child
- whether there is someone who will be able to provide valid consent for a medical and forensic consultation on behalf of the child, if the child is not old enough to do so themselves. For children in OOH, whether DCJ has provided consent.
- any existing safety plans.

## **15.6 Seeking consent for medical and forensic examinations**

### **15.6.1 The importance of seeking consent**

SAs are not to conduct medical and forensic examinations without specific indicators that a sexual assault may have taken place.

All patients with capacity are entitled to make their own decisions about their medical treatment. As a general rule, no operation, procedure or treatment may be undertaken without consent. The only exceptions are in an emergency or where the law otherwise allows or requires treatment to be given without consent.

As with all treatment, consent to the general nature of a proposed procedure or treatment must therefore be obtained from a patient. Failure to do this could result in legal action for assault against the health care practitioner who performs the procedure.

Consent must be freely given, sufficiently specific, and informed. Effort is to be made to explain things in terms or language the patient understands, supplemented where appropriate with diagrams or demonstrations.

Capacity is decision-specific (e.g. the capacity to decide to forgo a medical and forensic examination versus the capacity to decide not to use emergency contraception). Consent for each of the following components of the medical and forensic consultation will be addressed:

- consent for a medical and forensic consultation, which may include taking a history, performing an examination, documenting the examination findings on paper, and collecting biological samples and/or clothing
- consent for sexual assault photos

- consent for release or storage of forensic evidence, including samples from any early evidence collection processes.

Consent to participate in a research study must be sought in accordance with the requirements of the project's ethics committee approval.

A valid, written record of consent from the patient or appropriate substitute<sup>26</sup> must be obtained and recorded in the NSW Health Medical and Forensic Examination Record (MFER) or Child Sexual Assault Medical Protocol.

Patients with capacity 16 years and over need to be made aware that any information collected during the medical and forensic consultation can be disclosed only with their consent or in accordance with current legislation, including in response to a valid subpoena, and samples can be released to NSW Police only with consent or otherwise in accordance with current legislation (e.g. with a warrant). Sensitive images provisions may restrict access to some images that have been subpoenaed.

The medical and forensic examiner will:

- Inform patients of the nature and purpose of the medical and forensic consultation and explain how the information and/or evidence collected during the consultation could be used and who could have access to this information.
- Advise patients that they can decline the consultation or any individual aspect of the consultation (for example, rectal sampling) and this will not impact on services provided to them. Patients must be informed of potential consequences of declining part(s) of the consultation and this is to be documented on the relevant page of the MFER.
- Use appropriate support for people who require assistance to communicate.

District/networks will have systems and procedures in place to facilitate the communication of information required for gaining consent.

### **15.6.2 Identifying capacity to consent**

A person's right to make decisions is fundamental to their independence and dignity. Before assessing someone as not having the capacity to provide consent, the medical and forensic examiner needs to take all reasonable steps they can to support the patient through the decision-making process.<sup>27</sup> Patients will be assumed to have capacity to consent unless it is demonstrated that they do not have capacity.

The patient must have the capacity to consent. A person has decision-making capacity if they can:

- understand the facts and choices involved
- weigh up the consequences
- communicate their decision.

<sup>26</sup> For more detail, see NSW Health policy directive [Consent to Medical Treatment — Patient Information](#).

<sup>27</sup> Amended from Section 6 of the [Capacity Toolkit — NSW Justice](#).

Capacity to provide informed consent for a medical and forensic examination and/or the storage or release of the SAIK can be impacted by a number of factors including:

- age
- intellectual disability
- unconscious or semi-unconscious state
- alcohol and some medications/drugs
- the presence of severe injuries
- mental illness or disorder
- receptive language disorder.

Medical and forensic examiners will have the skills to assess capacity to consent. SANEs who would like assistance with assessing capacity to consent will be given timely access to a medical officer. The medical and forensic examiner is ultimately responsible for making this decision, whether they are a doctor or a nurse. Medical and forensic examiners are also to be willing to provide guidance to other NSW Health staff in these matters.

Decisions about capacity may require collateral information — for example from carers or mental health or ED staff. The decision to share information about an allegation of sexual assault with NSW Health staff outside the SAS will be made on a case-by-case basis, weighing the patient's right to confidentiality and the impact of withholding information on the patient's clinical and personal safety.

There is no single accepted way to assess capacity. For more information staff may:

- refer to the [Capacity Toolkit](#) produced by the Justice Department of NSW
- seek additional guidance from Ministry of Health Legal or the Guardianship Division of the NSW Civil and Administrative Tribunal.

How capacity was assessed is to be recorded in the client file and the ultimate decision recorded in the MFER.

### ***Age-related considerations***

Children and young people who have experienced sexual assault are to be made aware of the nature and purpose of the examination as appropriate to their age and language ability, and in a trauma-informed manner.

Generally, children and young people are capable of independently consenting to a particular medical treatment when they can understand fully what is proposed. This means that there is no set age at which they are capable of giving consent and medical and forensic examiners must make decisions on a case-by-case basis. However, as a general guide, children under 14 years of age will not usually have sufficient maturity and understanding to consent to a medical and forensic consultation.

Even where young people are considered to have capacity, it is good practice to involve the parent(s) (unless they are accused of the sexual assault) or a person with parental responsibility in the consent process where appropriate.

Children under 16 years of age do not have the option of temporary storage of their SAIK.

### **15.6.3 Seeking consent for children who do not have capacity to consent**

When children do not have sufficient understanding to consent to the medical and forensic consultation, their willingness to participate must still be determined and written consent from parent(s) (unless they are accused of the sexual assault) or an appropriate substitute must be obtained prior to the examination. It can be assumed that either parent is able to consent on behalf of their child unless a court order (including from the Family Court or Children's Court) stipulates something different.

This consent covers both the examination and the release of information and any forensic samples to NSW Police or DCJ. Note: There is no option for temporary hospital storage for children and young people under 16.

Occasionally, a parent delegates their responsibility for consenting to medical treatment on behalf of their minor child to another adult. This may occur in certain cultures (for example, in some Aboriginal families an extended family member, rather than the child's mother or father, might be responsible for giving consent).

Where NSW Health workers require advice about who is able to provide consent they are to:

- consult current NSW Health consent policy for further guidance (e.g. [Consent to Medical Treatment — Patient Information](#))
- contact NSW Health Legal and Regulatory Branch for advice or
- consult the Guardianship Division of NSW Civil and Administrative Tribunal.

Written consent from a parent/carer is not required when a notice under section 173 of the [CYPCP Act](#)<sup>28</sup> or a notice for a child or children in need of care and protection is received by the NSW Health service.

However, where a child is presented for examination under section 173, a medical and forensic examination will not be performed if the child objects. Staff are to refer to [Child Wellbeing and Child Protection Policies and Procedures for NSW Health](#) for further information with regard to NSW Health's role in coordinating section 173 medical examinations.<sup>29</sup>

### **15.6.4 Seeking consent from patients who require an interpreter**

District/networks will have systems and procedures that ensure that patients who are not fluent in English, who are deaf or who have other special communication needs are given appropriate

<sup>28</sup> Section 53 deals with current concerns that exist for the safety, welfare or wellbeing of the child or young person and an section 173 notice is a requirement for medical examination of a child and young person in need of care and protection.

<sup>29</sup> [https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2013\\_007.pdf](https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2013_007.pdf)

information and consent to treatment through the use of a healthcare interpreter, including telephone interpreter.

Both healthcare providers and patients have a right to request timely access to a free health interpreter. As a medical or medical and forensic examination is considered to be 'medical treatment', consent will be obtained from a professional interpreter (and not, for example a relative, or bilingual clinician) in accordance with the policy directive [Interpreters — Standard Procedures for Working with Health Care Interpreters](#).

Sensitivity regarding privacy in communities must be exercised. For small communities, the use of a telephone interpreter may be preferable, even if a local interpreter is available, or if the patient or the accused may know the interpreter. However, the patient's wishes must be respected. Where possible, the patient will also be given a choice of the gender of the interpreter.

If the interpreter is physically present, they are required to sign the MFER consent pages, provide their name and employee ID or Provider Number, and record the date and time. If interpretation is provided by telephone, the medical and forensic examiner will record these details.

#### **15.6.5 Seeking substitute consent for a medical and forensic consultation**

In deciding whether to obtain substitute consent or not, staff will determine whether the incapacity is likely to improve within the timeframes required for collection of forensic evidence. If this is likely, the patient will be left to regain capacity and their capacity established before any discussion about a medical and forensic consultation. The referring medical team will continue to provide care in the interim and an EEK can be considered.

Where a patient who is 16 years or over does not have capacity to consent to an examination (despite every effort to improve capacity, e.g. with simplified language diagrams or demonstrations), substitute consent must be obtained before commencing the consultation. For the purpose of a medical and forensic examination, a 'person responsible' within the meaning of the [Guardianship Act 1987](#) can provide substitute consent.

A medical and forensic examination will not be provided to a person who is unwilling to proceed with the examination or begins to resist the procedure, even if the consent is obtained from an authorised representative.

#### **15.6.6 The unconscious patient**

If the medical team caring for the patient with a decreased level of consciousness believes it highly unlikely the patient will regain capacity within the timeframe for forensic evidence to be collected, and there are clear indicators that a sexual assault has taken place (for example, signs of genital trauma, significant disturbance of clothing, or witnesses alleging sexual assault), substitute consent for the examination can be sought.

If there are concerns that the person responsible may be the perpetrator or the identity of the patient is unknown, consent can be sought from the [NSW Civil and Administrative Tribunal](#) (NCAT). This section refers solely to consent for the examination. Any evidence collected is to be safely stored and consent to release sought from the patient when they recover. If they do not recover their capacity to consent within three months, substitute consent for what to do with the evidence is to be sought.

The collection of forensic evidence will be provided as an adjunct to medical care (e.g. collecting blood for forensic testing at the same time as it is collected for medical purposes or collecting swabs prior to cleaning the genitals for medical treatment)<sup>30</sup> and will not adversely impact the provision of medical care, and:

- The medical and forensic examiner will liaise with the medical team about the optimum timing of the examination, considering the patient's general medical needs and forensic needs (e.g. if time allows, forensic genital swabs will be collected prior to cleaning the genitals for the placement of an in-dwelling bladder catheter).
- The medical and forensic examiner will offer advice about evidence preservation (e.g. storing clothing in paper bags or placing material used to clean the genital area in a labelled biohazard bag in cold storage) and early evidence collection (e.g. blood and urine for toxicology);
- The medical and forensic examiner can provide the examination as a stand-alone element within the patient's overall medical care (e.g. a forensic genital examination can be performed even if medical care does not require a genital examination, or can be performed at a separate time from a medical examination if good patient care requires that), provided there is appropriate consent.

If the medical and forensic examiner observes injuries that were not already detected by the medical team and that require treatment, this information will be shared with the team and that conversation documented in the patient's general medical record. The medical team will decide what information is appropriate to share with the person responsible.

#### **15.6.7 Patients who have been scheduled under the Mental Health Act**

A patient who has been scheduled under the [Mental Health Act 2007 \(NSW\)](#) as mentally ill or mentally disordered may still have the capacity to consent for a medical and forensic consultation and also to release of the SAIK. Capacity is to be assessed on a case-by-case basis. This may necessitate a direct assessment of the patient by the medical and forensic examiner and is to be informed by the opinion of the patient's treating psychiatrist or treating physician in the ED if a psychiatrist has not yet been appointed to the patient.

If the patient cannot consent to the medical and forensic examination/evidence collection, substitute consent from an authorised representative can be obtained. If the substitute decision-maker is the person accused of the assault, the medical and forensic examiner will liaise with the [NSW Civil and Administrative Tribunal](#) about appointing a guardian ([Sections 15.6.5](#)).

As part of the consent process, the medical and forensic examiner will inform the medical superintendent of the mental health unit (or their delegate, for example a member of the treating team, if the presentation is after hours) of the details of the medical and forensic consultation and discuss the possible implications for the patient's mental health and wellbeing.

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<sup>30</sup> Note: examinations provided solely for forensic purposes without being an adjunct for medical treatment require appropriate consent such as from NCAT.



When a medical and forensic consultation requires the patient to be transferred from one facility to another, this must only be done after input from both the medical superintendent (or their delegate) and the medical and forensic examiner.

A medical and forensic examination will not be provided if the patient is unwilling to proceed with the examination or begins to resist the procedure. A medical and forensic consultation can be offered at a later date if a patient regains capacity to consent within the forensic timeframe.

Information on preserving any evidence, including toxicological evidence, and the possible use of an EEK ([Section 15.3](#)), will be provided by the medical and forensic examiner to the referring mental health service.

SASs will:

- Work with mental health units to develop processes for alerting the SAS when an incapacitated patient has regained capacity or if the consulting psychiatrist believes the patient will never be able to provide consent.
- Have processes for gaining substitute consent for the ongoing storage or immediate release of a SAIK if it is determined that the patient will never be able to provide consent.

### ***Age-related considerations***

Consent is not required to release the SAIK for patients under the age of 16 years, regardless of their mental health status.

#### **15.6.8 Telehealth**

When using telehealth, SAS staff will adhere to the Agency for Clinical Innovation's guide [Telehealth in practice](#). This includes seeking verbal consent from the patient or substitute decision-maker ([Section 15.6.5](#)) for the use of telehealth during the medical or medical forensic examination.

### **15.7 Release of information**

#### **15.7.1 Patients 16 years and over**

Consent is required to release the MFER, forensic samples and any other relevant information to NSW Police, subsequent to a forensic consultation.

Where a patient's incapacity is temporary, consent to release is not to be obtained from a substitute decision-maker — a patient may subsequently regain capacity and be capable of consenting to the release of medical and forensic information.

Where a patient permanently lacks capacity, the [HRIP Act](#) sets out who can provide consent to disclose health information. Section 8 of the HRIP Act allows an authorised representative of the patient to provide consent to release health information. The Act defines an authorised representative as:

- an attorney for the individual under an enduring power of attorney OR
- a guardian within the meaning of the [Guardianship Act 1987](#), or a person responsible within the meaning of Part 5 of that Act, OR

- a person having parental responsibility for the individual, if the individual is a person under 18 years old, OR
- a person who is otherwise empowered under law to exercise any functions as an agent of or in the best interests of the individual

noting that a person is not an authorised representative of an individual for the purposes of this Act to the extent that acting as an authorised representative of the individual is inconsistent with an order made by a court or tribunal.

In situations where an authorised representative is not available or the SAS has concerns the authorised representative may not be acting in the client's best interests, they may contact the Guardianship Division of the [NSW Civil and Administrative Tribunal](#) (NCAT) who can appoint a guardian with the power to release information to NSW Police.

The NSW Health [Privacy Manual for Health Information](#) provides detailed guidance on where the [HRIP Act](#) allows law enforcement agencies, including police, to access personal health information. These are to be followed where the patient has not consented to release information.

When police request information to assist them to prosecute a crime, Section 11.2.7 of the [Privacy Manual for Health Information](#) sets out the principles to be considered when responding. All such requests are to be discussed with the SAS manager and/or another senior NSW Health service manager as appropriate. In addition NSW Health staff will also take into account section 316 of the [Crimes Act 1900](#) (see [Section 4.2.1](#)) in this context.

Note: A consent to release information collected in the MFER to Police permits that same information to be used in the preparation of an Expert Certificate. Where the Expert Certificate includes health information collected after the examination, then consent is required to use this additional information.

### **15.7.2 Patients under 16 years**

Safety is the first priority when providing care for children and young people under the age of 16 years. In all cases of children under the age of 16 undergoing a medical and forensic consultation, a Mandatory Report must be made to the [Child Protection Helpline](#) ([Section 4.1](#)) if they were not referred by the JCPRP/JRU. All pertinent medical and forensic information must be released to DCJ and Police, and consent is not required for this.

Safety takes precedence over protecting confidentiality of an individual's privacy. Chapter 16A of the [CYPCP Act](#) ([Section 22.2.2](#)) provides a legal framework for sharing relevant information.

## **15.8 Integrated medical or medical and forensic consultations**

The timing and content of the medical or medical and forensic consultation will be guided by a number of factors, including the choices of the patient, the history of the assault, the patient's clinical needs, and local resources. Whether or not a medical or medical and forensic consultation occurs is the choice of the patient and the consultation will be stopped at the patient's request at any time.

The patient will be offered the following choice of trauma-informed medical and forensic interventions, as relevant:

- a general medical history that includes information about the sexual assault
- a physical examination
- assessment of risk of STIs including HIV and appropriate management, which may include Post Exposure Prophylaxis (PEP)
- investigations as required for medical issues that arise during the consultation
- collection of material for forensic testing, if required by the history
- emergency contraception
- documentation of injuries
- treatment of injuries when present
- arrangements for continuing medical care.

Patients may also be offered photodocumentation of findings if clinically indicated ([Section 15.8.8](#)) and local resources and the expertise of the medical and forensic examiner permit it.

#### **15.8.1 Availability of medical staff of a particular gender**

Some patients may express a preference in terms of the gender of the medical and forensic examiner. Wherever possible, staffing patterns are to ensure availability of both male and female examiners in a timely manner. Where this is not possible, staff can consider deploying an EEK and delaying the examination until a staff member of the gender more acceptable to the patient is available or transferring the patient to another SAS. Note that medical and forensic examiners are hired based on their ability to comply with their position description, not their gender.

If a patient refuses an examination because of gender issues, this must be respected.

#### **15.8.2 Age-related considerations for integrated medical and forensic consultations**

##### ***Responding to children***

Medical and forensic interventions for children must be tailored to their developmental needs and follow the principles of high quality paediatric practice. For example:

- It may not be appropriate to take full DNA precautions with a young child (for example, if wearing a face mask could frighten the child), although what precautions were omitted and why must be documented.
- It may be appropriate to screen for other health problems, such as immunisation status, obesity, dental health and developmental delay.

When children present during the night or are highly distressed, consideration will be given to deferring the medical and forensic examination to a time more appropriate to the child's needs. This decision will be determined by the medical and forensic examiner after considering all the patient's medical and forensic needs (for example, the need for HIV PEP or whether a delay will seriously compromise testing of trace evidence) and in consultation with the SAS counsellor concerning the child and family's psychosocial issues.

Factors such as parental anxiety are not to result in children being examined in haste when the examination could be arranged at a more suitable time without compromising the collection of forensic evidence. However, if parental distress is having a negative effect on the child's emotional wellbeing, this will be factored into any decisions about timing.

Many children present outside the timeframe for trace evidence collection and with a history that makes the presence of a current documentable injury improbable (e.g. a history of oral–genital contact months ago). A non-urgent medical and forensic assessment will be scheduled at a time that is practical for the SAS and appropriate for the child's developmental stage and daily routine (e.g. avoiding meal or nap times). As the consultation would not be taking place acutely during a crisis presentation, a fuller, more holistic paediatric assessment can be done (e.g. screening for developmental or behavioural issues or reviewing immunisation needs). It is important to familiarise the child with the examination room.

The selection and interpretation of STI screening or testing in prepubertal children is a specialised area: medical and forensic examiners must have the appropriate expertise or seek input from a colleague with appropriate expertise.

A second consultation may be required to review injury healing or discuss test results or to review a child who was tired and/or did not wish to cooperate with the first examination. Follow-up care may also be required (for example, follow-up STI screening).

The medical and forensic examiner, in consultation with the parent/carer, will decide whether it is appropriate to perform a physical examination on an uncooperative toddler or infants — see also [Section 15.8.7](#) on managing pain and anxiety.

Consider contacting CASACAL for specific clinical advice on responding to children.

### ***Responding to 14 to 15 year olds***

Young people aged 14 or 15 who have experienced sexual assault may be seen either by child or adult medical and forensic examiners. The decision about which type of examiner is more appropriate will be made on a case-by-case basis and with the best interests of the young person in mind. Factors to consider include:

- the young person's wishes
- which medical and forensic examiner has the most appropriate skill set (e.g. an adult examiner may be better at assessing intoxication or providing emergency contraception)
- the young person's physical, sexual and emotional maturity
- whether the sexual assault occurred in an intra-familial setting (e.g. the response to sibling assault might call for the involvement of a child examiner).

SAS staff must consider whether a child is engaging in 'adolescent consensual peer sex' (see [Section 4.1.2](#) for discussion of the decision-making process to help inform whether a child is at risk of significant harm in these circumstances).

### **15.8.3 Provision of equipment and space**

Districts/networks will:

- Provide all necessary equipment for medical and forensic examinations, including single-use vaginal speculums and anoscopes, EEKs, DNA Decontamination Kits, Basic SAIK Packs and other forensic collection kits.
- Provide cold storage for 'wet' trace evidence that:
  - i. is securely lockable
  - ii. has separate doors for a fridge and freezer component or is a separate fridge and freezer OR is a lockable box that can be placed within a fridge or freezer and is clearly marked as not to be opened or removed except by a SAS counsellor or medical and forensic examiner
  - iii. is monitored to ensure the temperature remains in an appropriate range (fridge 2°C to 8°C and freezer -5°C to -25°C), and
  - iv. is alarmed if the temperature move out of the range, with processes in place for actioning a fridge alarm within one hour of its sounding. Suitable actions include taking urgent steps to rectify the problem and, if this cannot be done within a few hours, liaising with SAS staff about moving samples to another location. All samples that have come to room temperature for more than a few hours are to be identified and a mechanism put in place to communicate this to the Forensic and Analytical Science Service (FASS) if the samples are released to NSW Police.
- Provide a medical and forensic examination room in which 24-hour crisis response services are provided, which will:
  - have a duress alarm, have access-controlled doors and preferably be within the ED — this is a safety requirement for both patients and staff, as patients can be or become medically or psychiatrically unstable before or during the consultation
  - be in a designated (and if possible dedicated) room to reduce issues of cross-contamination
  - include a private bathroom with shower and toilet and a separate counselling space to accommodate history-taking and anyone attending to support the complainant, to reduce the number of people whose DNA might contaminate the physical examination space
  - be cleaned in accordance with local decontamination procedures
  - be thermally neutral (i.e. not too cold or too hot)
  - contain washable furniture and surfaces to reduce cross-contamination
  - include hand-washing facilities (with soap and running water)
  - have clean bed-linen and a gown that are DNA-free for each patient
  - provide an examination couch positioned so that the medical and forensic examiner can approach the client from the right-hand side
  - have sufficient light to perform the examination
  - have a desk or table and trolley to document and label specimens

[Section 23.2](#) provides more information on the physical environment requirements for SASs.

### ***Age-related considerations***

Children's hospitals may elect to perform all medical and forensic examinations in a Child Protection Unit. If so, there must be processes in place to assess whether it is safe to do so.

#### **15.8.4 Contamination reduction**

Districts/networks will:

- Adhere to best practices for collecting forensic evidence to minimise any potential for cross-contamination (these can be informed by the practices of the FASS, NSW Police and the Faculty of Clinical Forensic Medicine, Royal College of Pathologist of Australia).
- Have local procedures for contamination reduction.
- Use NSW Police DNA Decontamination Kits (if one is unavailable, ensure other suitable contamination reduction procedures are used and are documented).
- Record the steps taken to minimise contamination, and any issues that may have resulted in potential contamination of evidence, in the MFER or Child Sexual Assault Medical Protocol and the Expert Certificate, so that the impact of the event may be considered in light of the analytical results received.

### ***Age-related considerations***

Medical and forensic examiners will need to balance the value of DNA precautions with the developmental needs of the patient (e.g. it may not be appropriate to wear a gown when examining a young child). Deviations from standard practices must be documented and accounted for in the MFER/Child Protocol.

#### **15.8.5 Recommended time periods for forensic evidence collection**

SASs will:

- Comply with current NSW Police *Guidelines for the collection of forensic specimens from complainants and suspects*. These are updated on a six-monthly basis.
- Have a system in place to ensure that all medical and forensic examiners are informed when a change is made to the Guidelines.
- Ensure up-to-date Guidelines are readily available to medical and forensic examiners, including keeping an accessible copy near where medical and forensic examinations are performed.

A medical and forensic examiner may collect forensic evidence outside the Guidelines if there is a clinical indication to do so. If this occurs, the reasoning must be adequately conveyed to FASS via the MFER or Child Sexual Assault Medical Protocol.

#### **15.8.6 General anaesthesia**

It is never appropriate to use a general anaesthetic purely to collect forensic evidence. Nevertheless, evidence can be collected under anaesthetic provided:

- the anaesthetic is needed for medical reasons (e.g. to treat a vaginal injury or assess a potentially serious vaginal or anal injury in a child) AND
- collection will not impede medical care AND



- consent has been obtained.

### **15.8.7 Managing pain and anxiety**

The medical and forensic examiner will offer analgesia to patients in pain, as clinically indicated, and may offer anxiolytic medications for patients with high levels of distress if it is clinically safe to do so.

The analgesic needs of patients with disability who are nonverbal or preverbal will be carefully considered.

Ideally, samples for toxicology testing would be collected before medications are given – if samples are collected after medication administration, the medication, dose and time of administration is to be noted in the forensic medical record.

### ***Age-related considerations***

The risks and benefits of performing an examination on an uncooperative toddler or infant must be considered. The medical and forensic examiner can offer light sedation (e.g. nitrous oxide) if it is clinically safe to perform this and there is local light sedation protocol (which must be adhered to). Sedation is not to be routine practice but can be considered in select cases where the medical benefits outweigh any risks (e.g. when forensic specimens are critical to an investigation or when injury is suspected).

Consider contacting CASACAL for specific clinical advice on responding to children.

### **15.8.8 Photodocumentation**

This section refers predominantly to adults unless otherwise specified. For children, medical and forensic examiners are to refer to the NSW Health policy directive [\*Photo and Video Imaging in Cases of Suspected Child Sexual Abuse, Physical Abuse and Neglect\*](#). However, that policy directive needs to be operationalised in local procedures and is to be read in conjunction with the sections below on 'Age-related considerations' and 'Sensitive evidence provisions in the *Criminal Procedure Act 1986*' that apply to both adults and children.

Clinical imaging in the form of photo and/or video imaging is used to document and communicate clinical findings and can also contribute to the development of medical knowledge and skills and quality assurance processes. Clinical forensic photography can assist the medical and forensic examiner to provide medical evidence to the justice system by providing contemporaneous visual evidence that complements the written injury descriptions.

In relation to sexual assault medical and forensic examinations of **adults**, non-genital photos may be appropriate. Photos of ano-genital injuries or abnormalities that may be associated with the assault may be warranted in some circumstances (e.g. following serious injuries that are difficult to describe in words) — the patient's health, safety, wellbeing and access to the criminal justice and the needs of interagency partners will be considered when deciding whether to offer ano-genital photography.

The medical and forensic examiner will therefore consider: i) whether injuries can be adequately documented through written description and line drawings or whether photo-documentation is also required; and ii) whether photos are required for peer review or other primary clinical purposes.

Imaging, when it occurs, is one part of a holistic approach to meeting the health care needs of the patient in a trauma-informed and sensitive manner and must not be done as a standalone procedure, although it may be done at a dedicated second examination after the initial medical and forensic consultation, when this is in the best interests of the patient. When there is doubt about the nature of a particular abnormality or the appearance of an abnormality is expected to worsen over time, serial imaging may be required.

The images form part of a patient's health record and may be subpoenaed for evidentiary purposes or, for children and young people, accessed by interagency partners, and the medical and forensic examiner and patient/authorised representative must be aware of this. The process of capturing images and their role in any subsequent care or court proceedings requires careful consideration, as it may have a negative psychological impact on the person at the time or at a later date.

SASs will:

- Have the capacity for photodocumentation in the service if clinically indicated and with the appropriate consent. Where an individual medical and forensic examiner is unable to provide this service, the district/network will have in place procedures for alternative arrangements for photodocumentation (e.g. return in business hours, referral to another SAS for photodocumentation).
- Identify the immediate and longer term physical and emotional needs of the patient and carers and take these into account when considering the use of photo and video imaging.
- Comply with NSW Health guidelines and policies, including this policy and procedures and the NSW Health policy directive [Photo and Video Imaging in Cases of Suspected Child Sexual Abuse, Physical Abuse and Neglect](#), in relation to the purpose of taking such images, the secure storage and control of access to them, and the transmission and destruction for all images recorded during sexual assault examinations.
- Consider the use of photo and video imaging on a case-by-case basis.
- Ensure informed consent for the use of photo and video imaging by the patient or their authorised representative.
- Ensure that photo and video imaging is not excessive or unreasonably intrusive and is performed in a trauma-informed manner.

### ***Age-related considerations***

Photo and video imaging of child sexual abuse is guided by the NSW Health policy directive [Photo and Video Imaging in Cases of Suspected Child Sexual Abuse, Physical Abuse and Neglect](#) and so the information provided below are also best read in conjunction with that policy where the proposed imaging concerns children.

As part of the consent process, the medical and forensic examiner will explain that any records of examinations, findings, photographs, videos, samples/specimens taken in accordance with the consent/s given will be stored in accordance with NSW Health policy and the State Records Act 1998 for a minimum of 30 years and may be disclosed to:

- other clinicians for a second opinion

- parties requesting information from a NSW Health organisation under the legislation set out in the [CYPCP Act](#)
- NSW Police or the JCPRP, as part of an investigation
- the courts, under subpoena and in accordance with the sensitive images provisions of section 128 of the [Criminal Procedure Act 1986](#)
- parties in Family Court proceedings, under subpoena.

***Age-related considerations: adolescent patients***

Ano-genital imaging is not usually required in post-pubertal adolescent patients but may be used by paediatricians if they have limited experience in genital examinations in this age group and the district/network decides that this is the most appropriate way to fill this clinical gap. The images are primarily intended to allow second opinions and clinical audit.

***Age-related considerations: prepubertal children***

In relation to the sexual assault medical and forensic examination of children, the accurate evaluation of clinical findings is essential, including any genital injury or abnormality. However, the examination can be challenging (e.g. with a squirming infant or in Local Health Districts where case numbers are low and clinicians are concerned about their ability to maintain the skill of injury interpretation).

Photo and video imaging complements the naked eye examination (for example, by allowing a clinician to take as much time as they need to review a potential abnormality or to obtain a second opinion without requiring the child to undergo a second examination). Imaging in this situation is therefore best practice.

Consider contacting CASACAL for specific advice on photodocumentation for children.

Districts/networks will:

- Provide medical and forensic examiners who examine children with a colposcope or similar imaging technology with the capacity to take both still and video imaging; ideally simultaneously. The choice of scope will be informed by the clinicians (e.g. taking into account the layout of the room where it will be used and whether the clinician has access to an assistant during the examination).
- Provide safe storage for the images.
- Provide examiners with ready access to the images when they are preparing reports for the courts.

***Seeking consent for the capture and/or use of photo and video imaging***

Due to the issues outlined above, informed written consent must be obtained to capture photo and video imaging.

SASs will:

- Seek written informed consent for the taking of photos to document a clinical finding.

- Explain that any records of examinations, findings, photographs, videos, samples/specimens taken in accordance with the consent/s given will be stored in accordance with NSW Health policy and the *State Records Act 1998* for a minimum of 30 years and may be disclosed to:
  - other clinicians for a second opinion
  - NSW Police, as part of a criminal investigation
  - the courts, as part of a court report or expert certificate or under subpoena.
- Assure the patient that refusing consent for imaging will not in any way affect the care they will receive.
- Ensure that the section of the MFER on consent to imaging is completed when the person does consent to imaging.

### ***Consent for use of images for teaching and research purposes***

The patient may also be asked to provide specific consent for their de-identified photo and video imaging to be used in:

- teaching and education
- published and non-published research.

Consent for these purposes must be addressed separately. Teaching and research activities are to be compliant with relevant NSW Health policies and research must have approval from the relevant ethics committee.

### ***Withdrawing consent for the capture and/or use of images***

The patient may withdraw their consent for the capture of the imaging during the consultation, however they cannot do so after the consultation has been completed. They may withdraw their consent for the use of the de-identified photo and video imaging at any time. In some cases it may not be possible for images that have already been used for education or publication prior to the withdrawal of consent to be withdrawn from circulation.

### ***Guidelines for capturing and storing photo and video images***

Capture of imaging must be conducted in accordance with the NSW Health [Privacy Manual for Health Information](#), and must be undertaken by NSW Health Workers with suitable training and experience in the procedures required to comply with the requirements of photo and video imaging provided in this policy and procedures.

For images of both children<sup>31</sup> and adults:

- Collection of photo and video imaging must be relevant to the purpose, accurate, not excessive and not unreasonably intrusive.
- Photo and video imaging will supplement, not replace, other methods of documenting findings.
- The primary purpose must be to document a clinical finding for the medical record.

<sup>31</sup> These requirements are consistent with the NSW Health Policy Directive [Photo and Video Imaging in Cases of Suspected Child Sexual Abuse, Physical Abuse and Neglect](#)

- Other directly related purposes for collecting photo and video imaging include (but are not limited to):
  - providing an aide-memoire for potential future legal proceedings
  - assisting testimony in court
  - training, education and research where the appropriate consent is obtained and with approval from an appropriate ethics committee.

### ***Use of photographic and video images in a legal report***

Photographic and video images are not to be automatically included in a legal report as a matter of routine and images that constitute sensitive evidence (see below) are not to be included in a legal report at all. Where photographic and video images that constitute sensitive evidence are relevant to the legal report, their existence should be disclosed in the legal report. Photographic and video images (that do not constitute sensitive evidence) may be included in a legal report if the author concludes that a visual representation of an abnormality will augment the written description and accompanying body diagram of that abnormality (e.g. a complex collection of bruises with some abrasions can be difficult to describe in words).

If photographic and video images are not included in the report, it is good practice to disclose their existence.

### ***Sensitive evidence provisions in the Criminal Procedure Act 1986***

The sensitive evidence provisions of Part 2A of Chapter 6 of the NSW [Criminal Procedure Act 1986](#) may apply to sensitive images taken as part of sexual assault medical and forensic examination if they are subpoenaed by the defendant: it does not prevent the release of these images to a prosecuting authority or to a court. Sensitive evidence includes images that are obscene or indecent or show the person's genitalia or otherwise show the person in a state of undress. The Act provides that, in any criminal proceedings:

- A district/network is not required to produce, in response to a subpoena given by the accused person, anything it reasonably considers to be sensitive evidence.
- If the district/network relies on the Act to refuse to produce a thing that it would otherwise be required to produce under a subpoena, it must give the court and the accused person a written notice (a "sensitive evidence notice" ) that
  - i. describes the thing that the district/network considers to be sensitive evidence, and
  - ii. indicates that, as the district/network considers the thing to be sensitive evidence, the district/network is not required to produce the thing, and
  - iii. indicates that the thing will not be produced, and
  - iv. contains information to the effect that the accused person is entitled to view or listen to the thing in accordance with supervised access arrangements, and
  - v. sets out the name and contact details of the person (the "access supervisor") who is responsible for arranging access to the thing under the supervised access arrangements.
- The access supervisor in relation to a sensitive evidence notice must, as soon as practicable after receiving a written request from the accused person, give the accused

person, and any other person who has been engaged to assist with the accused person's case, reasonable access to the sensitive evidence under supervised access arrangements. This may require access to be given on more than one occasion. A person who is given access to a thing under supervised access arrangements must not, without the permission of the access supervisor:

- i. copy, or permit a person to copy, the thing, or
- ii. give the thing to another person, or
- iii. remove the thing from the custody of the access supervisor.

A district/network may approve arrangements that enable an accused person, and any other person who has been engaged to assist with the accused person's case, to view or listen to (but not copy) sensitive evidence held by the district/network, subject to such conditions as the district/network considers appropriate to ensure that there is no unauthorised reproduction or circulation of the thing and that the integrity of the thing is protected. The conditions may require access to take place under the immediate or general supervision of the district/network. A function of a district/network under a supervised access arrangement may, with the agreement of a prosecuting authority, be exercised by the prosecuting authority on behalf of the district/network.

- If during any criminal proceedings an accused person is given sensitive evidence, or a copy of sensitive evidence, or sensitive evidence is produced by a district/network, or sensitive evidence given to the accused person by a district/network is tendered by the accused person, the district/network will apply to the court to direct the accused person to return the sensitive evidence or copy to the custody of the district/network at or before the end of each day during which the proceedings are heard and direct that the sensitive evidence, and any copies of the sensitive evidence made for the purposes of the proceedings, be returned to the custody of the district/network. With their consent, the prosecuting authority can act on behalf of the district/network; in that case, sensitive evidence is to be returned to the prosecuting authority instead of the district/network.

To ensure these sensitive evidence provisions are enacted and help support NSW Health's interagency partners district/networks will:

- Develop local procedures on how the sensitive evidence provisions will be adhered to including who will respond to subpoenas relating to sensitive evidence and who may undertake the role of the 'access supervisor'.
- The district/network will notify the Office of the Director of Public Prosecutions (ODPP) via the central email address [health@odpp.nsw.gov.au](mailto:health@odpp.nsw.gov.au) of any subpoena from the Defence under section 281FA of [Criminal Procedure Act 1986](#) where the district/network has decided not to produce sensitive evidence. This notice simply needs to state the district/network has received the attached subpoena and issued the attached Sensitive Evidence Notice (and attach both documents) and an appropriate contact person in the district/network for any enquiries. The ODPP will ensure this information is provided to the appropriate ODPP officer who may follow up with the contact person with any enquiries.

### ***Documentation, storage and use of imaging***

SASs will:

- Ensure photo and video imaging is done using the hospital's or SAS's equipment where possible. Personal smart phones/tablets or any other device must not be used. Personal



cameras may be used where the images can be temporarily stored on a removable storage device provided by the SAS (e.g. memory stick) and the images then saved to a secure district/CPU drive and the device wiped.

- Ensure photo and video images remain the property of the district/network.
- Store photo and video images in a secure, networked medical and forensic or sexual assault e-folder and not in the general hospital medical record or cloud storage.
- Have local procedures/guidelines on photo and video imaging which include storage, release and electronic transfer of images including specifically for sensitive images.
- Document that photographs or videos were taken in the Medical and Forensic Examination Record/Child Sexual Assault Medical Protocol.
- In response to a subpoena, supply images in accordance with the sensitive images provisions of the [Criminal Procedure Act 1986](#) and notify the ODPP of any subpoena from the Defence under section 281FA of that Act where the district/network have decided not to produce sensitive evidence (see above for further detail).

#### **15.8.9 Support person for medical and forensic consultation**

General information about a support person during a SAS integrated psychosocial, medical and forensic response, including the choice of support person and actions to decrease potential negative impacts on them, is at [Section 14.2.4](#). The information below specifically concerns the support person in a medical and forensic consultation.

Anxiety about the medical and forensic consultation may be reduced if patients can have someone present whom they consider supportive. This may be a family member or friend and is in addition to the SAS counsellor.

Patients will therefore be offered the opportunity to have a support person present during particular parts or all of the medical and forensic consultation, as they wish. The patient may ask the support person to step out for any particular part of the consultation (for example, the physical examination).

#### ***Potential disadvantages of having a support person present during the medical and forensic examination***

The advantages of having a support person present during the medical and forensic consultation must be weighed against potential disadvantages, namely:

- Patients may self-censor the history (e.g. to avoid upsetting their support person or making them aware of information they would rather keep confidential).
- The patient's safety may be compromised if the support person might subsequently harm the patient (e.g. a partner who inflicts violence, or a non-supportive parent).
- There may be an increased risk of DNA contamination.

#### ***Age-related considerations: children***

When the medical and forensic examiner is getting information from the parent/carer about the assault, it is preferable to not have the patient present. The exceptions are when the child is very

distressed or very young. This reduces the risk of concerns that a child's subsequent history may be distorted by what they overheard.

If a forensic history is to be taken from the child, it is preferable for the support person to be a SAS counsellor only rather than a non-offending parent. This does not exclude the non-offending parent from being nearby.<sup>32</sup> The distress this could cause the child must be taken into consideration. Care must be taken not to ask leading questions; it is best practice to document the exact wording of the questions.

The general medical and social history can be taken from the parent, child or both, depending on the child's developmental stage.

It is preferable for the child's non-offending parent/carer to be present during the medical and forensic examination,<sup>33</sup> in addition to the SAS counsellor or other chaperone ([Section 15.8.11](#)). However, older children are to be given a choice about this.

***Age-related considerations: young people aged between 14 and 16***

It is preferable to have a SAS counsellor present as the only support person during the medical and forensic consultation — this may be as an auditory chaperone during the physical examination. If the young person wishes to also have a peer as an additional support person instead of another adult (such as a parent), this is to be considered.

It is particularly important for young people to be given an opportunity to spend some time with the medical and forensic examiner and/or SAS counsellor without their support person ([Section 14.2.3](#)). This allows for specific inquiry as to whether the patient has anything to disclose in confidence. This may involve careful negotiation with any friends, carers or family members who have accompanied the patient.

#### **15.8.10 Police officer presence during examination**

Police officers are not required to be present to witness the collection of sexual assault forensic evidence. If the patient make an unsolicited request for the police officer to be their support person during part or all of the medical forensic consultation, the officer may be present.

#### **15.8.11 Chaperone**

A chaperone will be present during the medical and forensic consultation, and will also be present for the physical examination. The chaperone must be a health professional acting in their capacity as a NSW Health worker. The advantages of having a chaperone present are:

- There is a support person for the patient, who can help monitor and respond to distress, and also support any other people in the room (for example, family members).
- The chain of evidence is maintained if the medical and forensic examiner leaves the room.
- The chaperone can assist in minor matters, such as obtaining extra equipment or in the case of a nurse assisting in the actual examination.

<sup>32</sup> Refer to NSW Health policy directive [Children and Adolescents - Safety and Security in NSW Acute Health Facilities](#)

<sup>33</sup> [Children and Adolescents - Guidelines for Care in Acute Care Settings](#)

- There is a level of protection for the medical and forensic examiner if there is a complaint about this stage of the consultation or the patient becomes distressed or violent.
- There is an advocate for the patient.

The chaperone will be a SAS counsellor for the majority of the medical and forensic consultation. However, services may establish local procedures for a nurse (from the EDs for example) to be the chaperone for the physical examination component of the medical and forensic consultation. The advantages of using the SAS counsellor as the chaperone include the following:

- continuity of care for the patient
- care from someone with the necessary psychosocial skills to support the patient
- assistance from someone who is equipped to manage vicarious trauma
- assistance from someone who has the time to support the patient
- assistance from someone who can put information in context (e.g. the SAS counsellor will have heard the details of the consent)
- assistance from a trained person if the patient's physical or mental health deteriorates.

SASs will:

- Ensure a chaperone is present during the physical examination, usually by the patient's bedside. The chaperone may act as an 'auditory chaperone'<sup>34</sup> if appropriate (e.g. the client wishes to have no one else present during the examination) and the medical and forensic examiner supports this.
- If both the SAS counsellor and medical and forensic examiner are male, they will offer a female clinician as a chaperone for the physical examination.

The name of the chaperone must be recorded in the examination notes.

If the medical and forensic examiner requires assistance conducting the examination (e.g. positioning a child) a second doctor or nurse is to provide this if possible and not the chaperone if the chaperone is a SAS counsellor. The assistant will be offered debriefing by the SAS counsellor.

### **15.8.12 Speculum examinations**

Following vaginal penetration, medical and forensic examiners will offer a speculum examination to check for injuries and, if clinically indicated, to collect trace evidence. Medical and forensic examiners must be able to perform a speculum examination in a sensitive and skilled manner. However, examiners who see only prepubertal children do not need this skill, as it is not an appropriate procedure for this age group in this setting.

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<sup>34</sup> An auditory chaperone is where the chaperone can hear the examination taking place but may be behind a curtain or have their view otherwise obscured.

### **15.8.13 Medical investigations**

By law, clinicians who order investigations are responsible for ensuring the results are actioned. This may happen within a SAS or may, with the patient's permission, involve another healthcare practitioner (for example, a GP or sexual health clinic) and may involve:

- checking the results
- conveying the results to the patient or parent/carer if appropriate
- developing a management plan for treating positive results and, where relevant, instigating contact tracing.

SASs will:

- provide medical support and/or supervision for SANEs who order investigations
- have robust processes in place to ensure the medical director or their delegate accesses and actions all medical test results.

### **15.8.14 Testing for sexually transmissible infections (STIs)**

Management of STIs after a sexual assault is important for the health and psychological wellbeing of the patient. In some cases there may be legal relevance to the detection of an STI (e.g. if it can be shown to be the result of the sexual assault, although this situation is rare). STIs following sexual assault are uncommon, however, and it is often difficult to correctly interpret a positive result as it may reflect pre-existing carriage or may be a marker of exposure rather than infection.

The medical director is responsible for ensuring the SAS has current, and regularly updated, clinical guidelines regarding STI testing for victims of sexual assault.<sup>35</sup> SASs will:

- Liaise with local sexual health clinics or public health units to develop local procedures for STI screening and prophylaxis.
- Test for STIs during the medical and forensic consultation when there are clinical reasons to do so (e.g. clinical indicators such as a purulent discharge, or when prescribing HIV PEP). Routine 'baseline' testing is generally not required for forensic reasons in adults.
- Provide initial care and arrange follow-up testing for young people and adults in accordance with the [Australian STI management guidelines for use in primary care](#), which have a specific chapter on testing following adult sexual assault. This may include advice about safer sex practices.
- Have robust processes in place for actioning the results of any testing done during the medical and forensic consultation. This includes providing prophylaxis if appropriate. For HIV PEP for adults and young people, this is to comply with the ASHM [Post-exposure prophylaxis for HIV: Australian national guidelines](#).
- Ensure medications and vaccines for prophylaxis are readily available at no charge to the patient. This may be via the SAS or by arrangement with another suitable service (for example, sexual health clinic).

<sup>35</sup> Refer to the 2014 Australian National Guidelines published on [www.sti.guidelines.org.au](http://www.sti.guidelines.org.au)

Testing for HIV is considered major medical treatment for the purposes of the [Guardianship Act 1987](#). When the patient lacks the capacity to consent to testing, a substitute decision-maker must be consulted ([Section 15.6](#)).

Any opinion provided in an expert certificate concerning the results of STI tests must include a discussion of the level of uncertainty in linking the diagnosis of an STI to a recent sexual assault. If it is beyond the scope of the medical and forensic examiner's expertise to comment, they will consult a sexual health or infectious diseases physician.

### ***Age-related considerations***

For adolescent patients, apply the adult advice above.

For children, it is particularly important to correctly identify STIs. However, not all STIs in children are transmitted sexually (e.g. some can be transmitted from mother to child at the time of the birth). Services will seek advice from a paediatric infectious diseases specialist, sexual health physician with paediatric experience, or CASACAL if they are unsure about which tests to order, how to interpret a test result, and what treatment may be required.

In children, HIV PEP is to be offered in accordance with either ANZPID [Guidelines for Post-Exposure Prophylaxis \(PEP\) for Blood Borne Viruses In Children](#) or ASHM [Post-exposure Prophylaxis for HIV: Australian National Guidelines](#). The ASHM guidelines may be more suitable for adolescent patients.

### **15.8.15 Emergency contraception**

SASs will:

- Ensure emergency contraception is readily available.
- Offer emergency contraception to all women and girls at no charge where a risk of pregnancy is identified, unless medically contraindicated.

### **15.8.16 Discussion of findings**

Patients and carers often have health concerns following the sexual assault and may have questions about the findings of the medical and forensic examination.

Following a consultation, the medical and forensic examiner will:

- Discuss any findings from the examination with the patient and, where applicable, a non-offending carer, allowing sufficient time to deal with any issues that arise.
- Provide an opportunity for the parents or carers to express their concerns in the absence of the child or young person.
- Bear in mind the age and intellectual ability of the patient when discussing the findings.

If necessary for patient care, the medical and forensic examiner are to discuss any medical findings with the SAS counsellor. It is good practice to have this discussion with the patient involved so that they are aware of, and consent to, the information being shared.

If relevant to the criminal investigation, and only with the patient's permission, the medical and forensic examiner will discuss any significant information with NSW Police (e.g. that there are concerns about the patient's safety after discharge or information relevant to the crime, particularly if there is a time-critical element such as a condom at the crime scene). Permission may not be required in the circumstances outlined in NSW Health policy [Domestic Violence — Identifying and Responding](#). Following an out-of-hours presentation, this could take the next working day and can occur by phone.

### ***Age-related considerations***

Following a medical and forensic examination of a person under 16 years of age, the medical and forensic examiner will share any significant findings with the JCPRP SHC/HC.<sup>36</sup>

#### **15.8.17 Issuing of medical certificates**

Patients and carers attending a SAS in crisis following a recent sexual assault are to be offered a medical certificate to enable them to take time off work/study in the immediate post-assault period if required and/or support letters for students who are due to undertake an assessment activity.

The amount of time off provided through the certificate will depend on the clinical situation (e.g. a person with acute mental health needs may need medical review sooner than another patient might).

The certificate will not detail that the patient has reported a sexual assault, unless the patient requests this detail is included.

### **15.9 Continuing medical care**

SASs will:

- Where possible, offer all clients accepted for counselling a holistic medical assessment and plan. This is because SASs see a vulnerable and under-screened population.
- When clinically required after an urgent medical response, provide follow-up medical appointments regarding injuries, pregnancy risk and pregnancy, testing for and treating STIs, and other general medical matters to patients (as relevant to the history of the assault). Note: patients who have commenced HIV PEP will need follow up with an S100 prescriber or sexual health clinic.
- Where it is not possible to provide follow-up medical care in-house by the SAS (noting that this is good practice), facilitate referral to other services (e.g. sexual health clinic or GP). Referral processes will balance the receiving healthcare practitioner's need for accurate information (so that proper care can be delivered) and the patient's preferences for what information is shared and in what format.
- Provide advice about safer sex practices if relevant to the case history.
- Provide a written management plan to the patient when medical follow-up is arranged.
- Seek the patient's permission for the SAS to contact them after discharge and assist with adhering to the follow-up plan.

<sup>36</sup> As permitted by Chapter 16A of the [CYPCH Act](#), Sexual Assault Communications Privilege and sensitive evidence provisions need to be considered when determining what information should be shared.



- Offer a second medical and forensic examination if new information comes to light (e.g. the patient remembers another act or new swelling develops) or if the medical and forensic examiner feels that a supplementary examination will clarify or augment the first examination (e.g. if there is uncertainty about whether an abnormality is a bruise). In the latter case, consideration will be given to photodocumentation, to assist in determining whether abnormalities have changed over time ([Section 15.8.8](#)).

In districts where SANEs are employed, follow-up health care for adults (14 years and over) can in most cases be provided by SANEs. In only a small number of cases will it be more appropriate for this care to be provided by a doctor.

### ***Age-related considerations***

Follow-up medical care for prepubertal children will usually only be provided by healthcare practitioners with the necessary expertise or access to the necessary expertise (for example, through CASACAL or local paediatric services).

#### **15.9.1 Transfer of continuing medical care between services**

Patients who live outside the SAS's catchment area are to receive an active follow-up psychosocial and medical and forensic response (where appropriate) by their local SAS. This may require liaison with the relevant JCPRP SHCs/HCs (where a child or children are involved), a range of medical staff, the patient's home SAS, or other agencies or health organisations, with relevant consents. Local procedures are to be in place to facilitate a timely and appropriate 'warm' referral from one SAS to another.

If patients require medical follow-up from outside the SAS's home facility, the medical and forensic examiner is responsible for providing a summary of care.

SASs will liaise with the JH&FMHN in relation to the provision of ongoing medical and other care of inmates referred from Correctional/Detention Centres, Juvenile Justice Centres or other restricted settings as appropriate ([Section 10.2](#)) following sexual assault.

In cases where the crisis response was provided by another SAS, the patient's home service will accept the referral and facilitate ongoing care<sup>37</sup>.

Where interstate services are involved, the SAS will liaise with these services as required in accordance with the relevant cross-border protocols.

### **15.10 Referral to or consultation with tertiary hospitals or other districts/networks**

SASs will:

- Ensure that all medical and forensic examiners working with people under 16 years old understand when and how to consult with CASACAL

<sup>37</sup> Using or disclosing information as part of a referral for continued treatment is permitted under the HRIP Act where it is reasonably expected. Chapter 16A of the CYPCP Act may also be relevant for sharing information not related directly to continued treatment.

- Have processes in place: (i) to transfer patients to a tertiary referral centre when a patient needs to be referred for further care (e.g. when a second medical opinion is needed and the LHD does not have the necessary expertise); and (ii) for information sharing between the referring and receiving centres.
- Have processes in place to transfer patients to another centre when an urgent medical and forensic consultation is required and a medical and forensic examiner of the gender acceptable to the patient is not available.

### **15.11 Packaging and storage of samples and other forensic evidence**

Medical and forensic examiners will:

- Check that all carbon copies of the MFER/Child Sexual Assault Medical Protocol are legible and make photocopies if they are not.
- Label, package and seal forensic evidence in accordance with the instructions in the forensic kit or MFER.
- At the end of the consultation, hand all the evidence, the MFER/Child Sexual Assault Medical Protocol and any other medical records to the SAS counsellor for safe storage unless it is the service's practice for the examiner to store the material safely.

### **15.12 Storage and destruction of SAIKs for people over 16 years**

A patient who wishes to release their evidence to NSW Police should choose the Immediate Release option and sign the relevant section of the MFER.

If the patient is undecided about releasing the SAIK to NSW Police, they should choose the Temporary Hospital Storage option.

SASs will:

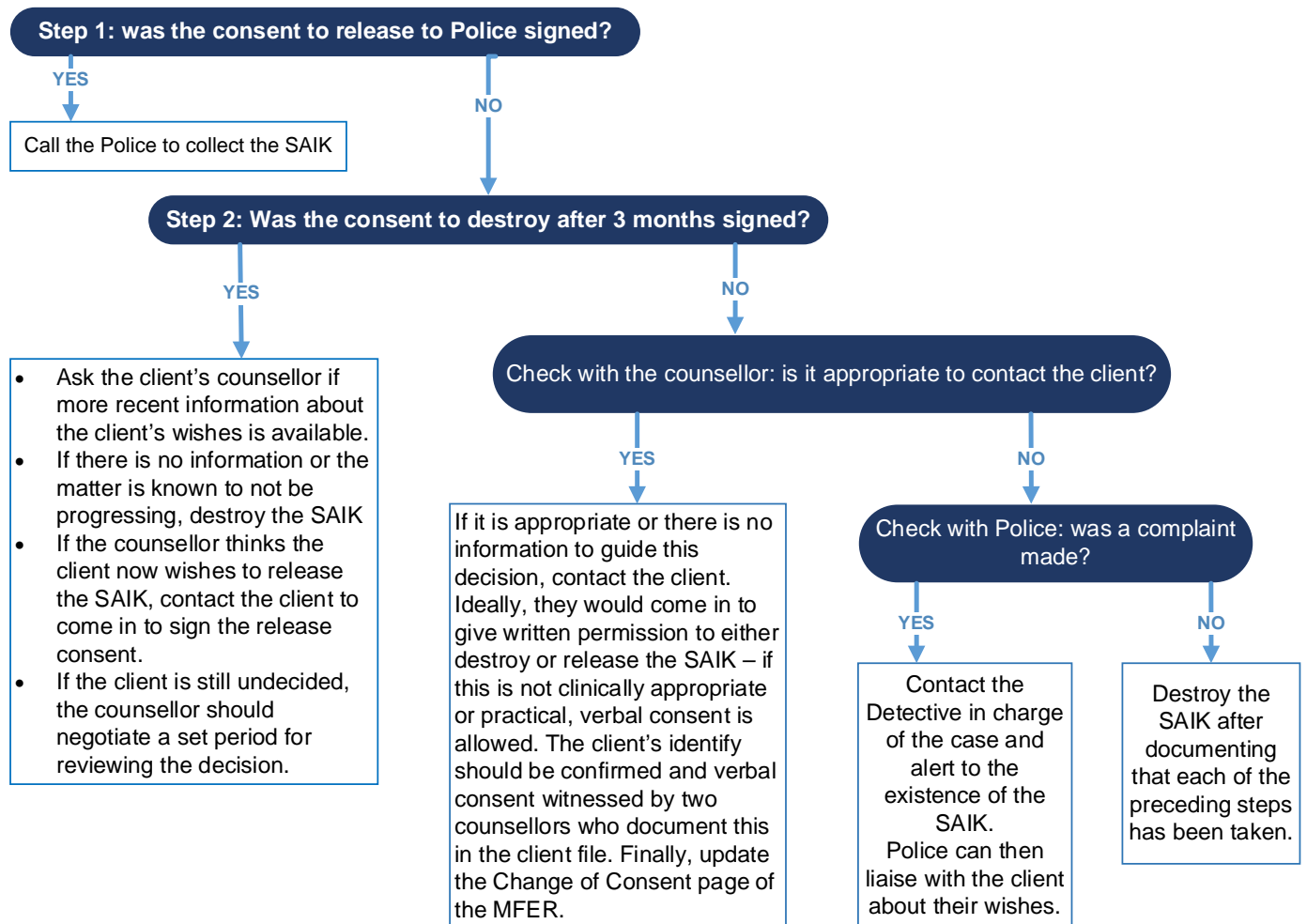
- Store forensic equipment and SAIKS or any other collected evidence (e.g. clothing, early evidence kits, toxicological samples) in secure storage in designated areas with sufficient space to store material for three months. Securing the evidence may involve temporary safe storage in or near the medical and forensic examination room at the time of an after-hours examination, with transfer in business hours to longer-term storage within the SAS if appropriate.
- Store forensic evidence in accordance with local procedures. SAS may contact FASS or the Ministry of Health to discuss best-practice storage to inform local procedures.
- Ensure that victims are provided with written information about what will happen to their SAIK.
- Have a register identifying: what evidence was collected, when, from whom and by whom; the location of the evidence if it was stored offsite (e.g. an EEK at a remote facility); and when the evidence was collected by NSW Police with the officer's details (name, designation, initials) ([Section 15.14.3](#)).
- Have processes in place for following-up with NSW Police when SAIKs that have been signed for Immediate Release have not been collected within a week.

- Have processes in place that allow a patient to choose the Temporary Hospital Storage Option or have their SAIK destroyed if they initially consented to Immediate Release but have changed their minds, provided the SAIK has not yet been released to NSW Police.
- Have processes in place when a patient who chose Temporary Hospital Storage later decides to release their information to NSW Police that:
  - Ensure that the Change of Consent Form accompanies the SAIK when it is handed to NSW Police.
  - Allow for situations when a patient is unable to unwilling or unable to attend the SAS to sign the form by providing alternative pathways. This can be done in writing, with a scanned or faxed consent form with a signature that matches those on the MFER, or verbally. If done verbally, this will include checking proof of identify, having two SAS staff witness the change of consent (e.g. by hearing verbal consent being giving on speakerphone or by having consent repeated to a second SAS worker), documenting the change of consent process used in the client file, and completing the Change of Consent Form.
- Store evidence for a minimum period of three months if the patient has chosen the Temporary Hospital Storage option or the medical and forensic examiner omitted to complete this section of the MFER.
- Attempt to contact the patient prior to the destruction of their SAIK. The lengths to which the SAS is to go in attempting to contact patients can be informed by factors such as whether there is a police investigation, whether the patient is still engaged with the SAS, the patient's current mental health and what is known about their wishes. If known, use the patient's preferred method of communication.

See Figure 13 below for guidance on how to destroy SAIKs.

**Figure 13: Guidance on how to destroy SAIKs**

**Guidance on how to destroy SAIKS**



**How to destroy a SAIK**

- Use gloves at all times.
- Check that the original SAIK notes are still in the client's file – if they are not, put the most legible of the carbon copies into the file as a replacement.
- Put the blue, pink and any yellow pages in a secure disposal waste bin.
- If any outer SAIK envelopes or other envelopes or paper bags have the client's name on them, put them in a secure disposal waste bin.
- Put the padded envelope from within the large gold SAIK envelope, and any evidence bags or biohazard bags, in a contaminated waste bin.
- Update the SAIK Register and update the client file, documenting what steps were taken and why.

**Age-related considerations**

Children under 16 do not have the option of temporary hospital storage, as evidence destruction is not an option for patients under 16 years of age. All SAIKs and any early evidence must be handed to JCPRP or NSW Police on request, and the SAIK register updated.

## **15.13 Taking forensic samples from a person of interest**

If an individual medical and forensic examiner employed by NSW Health undertakes work for NSW Police related to the collection of forensic evidence, such as intimate samples, from a person of interest in a sexual assault matter, this must be done in accordance with any NSW Health statewide and local secondary employment policies. Any activities in this regard are in the context of the employment with NSW Police, not NSW Health, and so the policies, procedures and processes of NSW Police for gaining consent from the person, taking and handling samples, and documenting the consultation apply.

A medical and forensic examiner employed by NSW Police must take great care to minimise any potential contamination of evidence. The medical and forensic examiner is not to examine the person of interest in their role with NSW Police if they have examined the victim for the SAS in their role with NSW Health (or vice versa) unless there are no other alternatives.

In undertaking this sort of work in accordance with secondary employment policies, medical and forensic examiners employed by NSW Health must not use NSW Health facilities (including, but not limited to, medical and forensic examination rooms, equipment, and letterhead) unless the appropriate agreements are in place in their district/network to use Health facilities for this purpose. They must also undertake this work outside of their employment with NSW Health (i.e. while they are not on shift/being paid by a NSW Health agency such as an district/network) and there must be no conflict of interest between their role as a NSW Health medical and forensic examiner, the district/network providing the services to the victim, and their role with NSW Police.

If an individual medical and forensic examiner employed by NSW Health undertakes any activities for the defendant in a sexual assault matter including, but not limited to, the preparation of reports and provision of expert evidence (but excluding facilitating access to sensitive evidence as outlined in [Section 15.8.8](#)), this must be done so in accordance with any NSW Health statewide and local district/network secondary employment policies.

## **15.14 Medical records and medico-legal matters**

### **15.14.1 Adequacy of content for medico-legal reports**

General guidance on SAS records including general content, security and confidentiality, storage, retention and so on is provided in [Section 22.1](#). Below is information that specifically relates to the content of SAS medical records and will be read in conjunction with the guidance provided in [Section 22.1](#). In this context, SASs will:

- Provide MFERs and the Child Sexual Assault Medical Protocols for medical and forensic examiners to use during the consultation.
- Ensure that medical and forensic examiners use an MFER or Child Sexual Assault Medical Protocol during each medical and forensic examination (selecting the relevant form for the case at hand) and complete all relevant sections.
- Record the medical elements of the consultation in the final page of the MFER, if one is used.
- If an MFER is not used, because the patient has chosen medical care only, record the consultation in the SAS client file. This information may become the basis for a [Recognition Payment](#) in the future.

- File the MFER or Child Sexual Assault Medical Protocol and other records in SAS files, not in a general medical record.
- Have processes in place for documenting any medications prescribed that balance patient safety with patient confidentiality.
- For each case, liaise with the ED (i) the best discharge code to use in the electronic medical record (eMR), (ii) whether a Consult Note is to be written in the eMR, and (iii) what is to be uploaded to MyHealthRecord. The patient's wishes will be taken into account for MyHealthRecord.

#### **15.14.2 Age-related considerations: use of the adult MFER for 14 and 15 year olds**

The Adult Medical Forensic Examination Record, rather than the Child Sexual Assault Medical Protocol, may be used in cases where it is considered more appropriate and the child is post pubertal.

However, the following legal requirements for this age group need to be considered:

- They cannot be offered the Temporary Hospital Storage option. It is therefore important that, prior to the young person or parent/carer signing the consent to the examination, they are informed that this consent includes release to NSW Police.
- It is not necessary for the *Consent For The Release Of Information to Police* form to be signed for those under the age of 16 years because there will be mandatory notification to JCPRP/DCJ. A note that this form is not required will be made in the MFER in lieu of a signature.

#### **15.14.3 Forensic register**

SASs will:

- Maintain a register or registration system that tracks all SAIKs and EEKs completed for SAS clients.
- Keep the register in a secure area.

The register will include the following information:

- the names of the victim, the medical and forensic examiner, and the SAS counsellor present during the medical and forensic consultation
- the SAIK number and a list of all items collected that are not stored in the SAIK package (e.g. toxicology samples, EEKs, bags of clothing) and an indicator of where they are stored (e.g. SAS fridge)
- the date of examination and collection
- the date and time of transfer to NSW Police or the date and time of evidence destruction
- the name of the person who handed the evidence to NSW Police or was responsible for its destruction
- the name of the NSW Police officer collecting the evidence.

#### **15.14.4 Preparation of medico-legal reports, statements and expert certificates**

Medical and forensic examiners may be called to give impartial evidence in court, based on their firsthand experience consulting with the patient, and to provide their independent expert opinion



based on the consultation findings, any investigations or images, and any relevant information provided by NSW Police (e.g. evidentiary statements).

As part of their role in conducting a medical and forensic examination, medical and forensic examiners may prepare statements and expert certificates that record the consultation and their expert opinion in a timely manner and in a format acceptable as evidence in court. This is to be completed as soon as possible on request. In complicated cases (involving children or significant injuries), medical and forensic examiners will try to complete expert certificates as soon as practicable after the medical and forensic examination to assist in ensuring accuracy.

Examiners cannot provide a certificate of expert evidence for adult patients without the appropriate consent ([Section 15.6](#)).

The district/network is responsible for:

- the provision of medico-legal reports in support of the needs of the justice system in connection to the provision of SAS medical and forensic responses
- provision of support to report writers if issues arise as a result of providing medico-legal reports
- ensuring medical and forensic examiners are aware of the requirements under Expert Witness Code of Conduct in schedule 7 of the [Uniform Civil Procedure Rules 2005](#).

SASs will ensure that:

- Expert certificates are released only with valid consent.
- Examiners and reviewers are remunerated for writing expert certificates.
- Medico-legal reports are reviewed by a Fellow of the Faculty of Clinical Forensic Medicine, Royal College of Pathologists of Australia OR a medical and forensic examiner who has a Master in Forensic Medicine degree from Monash University OR a medical and forensic examiner who has completed the ECAV Unit of Competency Supervise Medicolegal Work. A doctor employed as a CASACAL clinician can review cases involving children under 16 years. Expert review will be conducted by medical practitioners actively working (or have recently worked in the last 3 years) in the field they are reviewing. The medical and forensic examiner and reviewer will discuss any issues where there is disagreement and seek to come to a resolution.
- Where a SAS temporarily lacks an appropriate reviewer in-house, the SAS will have a service-level agreement with another district/network to provide the review, and remunerate the second service for this.
- Ensure that privacy law is adhered to if material is being transmitted between an examiner and a reviewer, especially when the review is in a different district/network. This includes the MFER/Child Protocol, any other medical notes, images and draft certificates.
- In cases where the medical and forensic examiner is not sufficiently qualified or experienced to provide an opinion on their findings, arrange for an experienced peer or designated medical director to write a second report offering opinion evidence.
- There is a version control mechanism in place for medico-legal reports/expert certificates. Version control refers to keeping copies of (i) the original document submitted for review, (ii)

the written feedback of the reviewer and/or notes from a verbal discussion between the author and the review, as documented by the reviewer, and (iii) the final version of the document. There may be multiple versions if a document undergoes more than one review cycle. Only the final version of medico-legal reports/expert certificates are to be placed on the patient's SAS record, however drafts will be retained where they are not routine in nature and contain significant or substantial changes.<sup>38</sup>

- The final version of all medico-legal reports/expert certificates is placed on the patient's SAS file for future reference.

Medical and forensic examiners will comply with the Expert Witness Code of Conduct in Schedule 7 [Uniform Civil Procedure Rules 2005](#), including acknowledging *the extent to which any opinion they express involves the acceptance of another person's opinion, identifying both that other person and the opinion expressed by that person*.

Medical and forensic examiners may refer for guidance to the [ECAV](#) guidelines for writing an expert certificate, which are on the [ECAV](#) SharePoint website available to all NSW Health medical and forensic examiners.

### **Age-related considerations**

When having their expert certificates reviewed, child medical and forensic examiners can access CASACAL and are strongly encouraged to do so when there is insufficient local expertise.

### **Preparation of medico-legal reports, expert evidence or other activities for the defence**

If an individual medical and forensic examiner employed by NSW Health undertakes any activities for the defendant in a sexual assault matter including, but not limited to, the preparation of reports and provision of expert evidence (but excluding facilitating access to sensitive evidence as outlined in [Section 15.8.8](#)), this must be done so in accordance with any NSW Health statewide and local district/network secondary employment policies.

In undertaking work for the defendant in accordance with secondary employment policies, medical and forensic examiners employed by NSW Health must not use NSW Health facilities (including, but not limited to, medical and forensic examination rooms, equipment, and letterhead). They must also undertake this work outside of their employment with NSW Health (i.e., while they are not on shift/being paid by a NSW Health agency such as an district/network) and there must be no conflict of interest between their role as a NSW Health medical and forensic examiner, the district/network providing the services to the victim, and their role with the defendant.

One exception would be a SAS preparing SAS medico-legal reports, expert evidence and other forensic activities in response to a request from the defence where:

1. the patient was a client of the SAS approached, and
2. the patient consents to the request.

<sup>38</sup> In the unusual circumstances that an expert certificate is released to Police or ODPP and then subsequently amended based on expert review, then the original certificate, the reviewer's comments and the updated certificate will all be kept on the patient's SAS record to explain discrepancies between the two versions if necessary.

#### **15.14.5 Managing requests for medico-legal reports, statements and expert certificates**

SASs will develop systems to record/register all requests, including written and email requests, for medico-legal reports. This will include medical reports for Victims of Crime compensation applications, reports for the Children's Court, statements to NSW Police, and expert certificates. This system will record:

- the date the request was received
- the date the request was sent to the relevant SAS staff member
- the date the report is due to be returned
- consent of the adult patient (or their authorised representative) to release the information
- the date the report was signed off by the medical director (for court reports and expert certificates)
- the date the report was submitted to the requesting organisation.

All requests for court reports and expert certificates will be forwarded to the SAS to be registered prior to being sent to the medical and forensic examiner or other SAS worker.

The SAS will have local procedures in place for:

- tracking the progress of each court report or expert certificate
- handling significant discrepancies between the opinions of the author of the court report or expert certificate and the reviewer.

#### **15.14.6 SAIK summary reports**

SAIK Summary Reports are reports generated by FASS for each individual patient that indicate what samples were tested, a summary of results of testing (including DNA analysis) as well as giving quality control feedback.

SAIK summary reports are to be stored separately to other SAS patient files. Where a client or the client's guardian or legal representative requires access to their file, the file is to be released in accordance with current policy and procedures, without the SAIK summary report included. The SAS will inform the client that:

- there are quality assurance records provided to NSW Health from NSW Police that require consultation with NSW Police before access is provided, and
- ask the client whether they would like to consult with NSW Police about accessing the report, or not.

Medical and forensic examiners should not access or refer to SAIK summary reports when preparing Expert Certificates, as SAIK summary reports contain preliminary results only.

If the client wishes to access the SAIK summary report, the SAS will support the client to request access from NSW Police. NSW Police will either provide access directly, or advise the client if there are public interest reasons not to disclose such as impact on an investigation or prosecution. If NSW Police request the SAS provide the client access to the SAIK summary report, the client is

to be shown the report in the company of a medical and forensic examiner or other SAS representative if appropriate, to explain the content and meaning of the report.

## 16 ONGOING THERAPEUTIC INTERVENTIONS FOLLOWING SEXUAL ASSAULT

### 16 Ongoing therapeutic interventions following sexual assault: summary

- SASs will provide ongoing therapeutic interventions that are evidence-based and evidence-informed, with the key elements of interventions to include:
  1. safety and stabilisation
  2. assessment
  3. ongoing case plans
  4. individual and family counselling
  5. casework and client advocacy
  6. review
  7. group work.

In the context of sexual assault, the struggles facing clients are not to be identified as arising from 'something wrong with them' but rather arising through distressing or disabling responses because of 'what has happened to them' (Bloom & Farragher, 2011). Therapeutic interventions by SASs will therefore:

- focus on the safety (physical and psychological) and stabilisation of the person who has been assaulted
- acknowledge that the impact of the sexual assault is also influenced by the victim's personal history (including trauma history), the severity, extent and duration of the abuse, the relationship with the perpetrator, past and current supports, and social and cultural context.
- recognise the link between sexual assault and other forms of violence, abuse and neglect, including an increased risk of re-victimisation.
- in any intervention provided, support victims to reveal the nature and context of the violence, place responsibility for the violence with perpetrators of that harm, and uphold the victim's dignity and worth
- identify the strengths, resilience and actions of resistance of the person who has experienced sexual assault (see Coates & Wade, 2008 for more on resistance).
- provide a supportive environment to identify and address the effects and ongoing legacies of sexual assault, including neurobiological impacts, fear, shame, responsibility, secrecy, anxiety, helplessness, and self-blame
- identify and respond to other identified needs of the client, including those presenting with complex trauma
- empower the client to hold on to truths about themselves and others that contradict the layers of false identity they were conditioned to believe by the violence.
- connect the client to a true and meaningful sense of who they are, and how they can extend meaningful connection to others.

SASs will provide ongoing interventions that are evidence-based and/or evidence-informed by offering a range of flexible holistic interventions (Henderson & Bateman, 2010, p. 52), with the key elements of these SAS interventions to include:

1. safety and stabilisation
2. assessment
3. ongoing case plans
4. individual and family counselling
5. casework and client advocacy
6. review
7. group work.

A brief outline of each of these key elements is provided below, and additional information, including on therapeutic modalities, is in [Appendix 7](#).

### **16.1 Safety and stabilisation**

One of the first stages of working with someone who has experienced sexually assault is establishing safety. Some therapeutic models of working with people who have experienced violence call this 'stabilisation'. This refers to working with people to gain or regain a sense of internal and external safety. The resources and time required to do this will depend on a person's individual circumstances, other existing issues and the support networks they have available to draw upon.

Sexual assault violates core experiences of trust and connection and dismantles a person's sense of safety. The common legacies of sexual assault, including neurobiological impacts, isolation, guilt and shame, self-erasure, violation and powerlessness, can render people overwhelmed and emotionally, physically, socially and relationally incapacitated. At the initial stage of engagement with clients, the building of physical, psychological and emotional safety in partnership with them is imperative. This will be achieved through practice that aligns with the guidance in these policy and procedures, and in particular the principles of intervention ([Section 3.2](#)), key practice approaches for responding to sexual assault ([Section 3.4](#)), addressing access and equity issues ([Section 13.2](#)), and safety and risk assessment and management ([Section 13.5.1](#)).

It is unrealistic for all clients, whether children or adults, to have achieved absolute safety before they engage in counselling. However they may be 'safe enough'. While there may be circumstances where it is assessed the level of risk prohibits the person from effectively participating in counselling, the initial phases of counselling with a client or family may involve working towards safety. As noted by Kezelman & Stavropoulos (2012, p. 72): "[t]he evidence base reflects that some clients do so well in this phase that they either have no need to complete the other two phases [see [Section 16.4](#)] or choose not to do so. Others never move beyond or complete this phase, and instead use it as life maintenance and a source of needed support".

### **16.2 Comprehensive assessment**

Undertaking a comprehensive assessment of a person's unique individual needs and strengths is an important aspect of any intervention and will be done in a way that builds on the information



from the initial assessment ([Section 13.5.2](#)). In providing a comprehensive assessment, the SAS counsellor will take a holistic view of the client, including their family and environmental and cultural influences, and will work in partnership with the client to gain a clearer understanding of what they have experienced; the outcomes or consequences of sexual assault; acts of resistance and strategies for managing the outcomes and consequences of sexual assault; and supports and protective factors. SAS counsellors will consider the use of validated assessment tools to assist the assessment process.

In a comprehensive assessment, the SAS counsellor will constantly evaluate the client's responses and adapt their assessment accordingly to avoid re-traumatisation. The following factors may be considered (if they weren't already in the initial assessment) and as guided by the client:

- the social context of the person's life, including age, relevant developmental history, culture, immigration or refugee status, sexual preference, abilities, personal relationships, and social wellbeing such as housing, income, employment or educational status, social isolation or connection to support networks
- the nature of the sexual assault in terms of things of significance to the client (e.g. the length of time the abuse occurred, relationship to the perpetrator)
- experiences of other forms of violence, abuse and neglect, such as domestic and family violence and relevant information (e.g. location and risk of perpetrator)
- the discovery of the sexual assault, such as disclosure by the client or reporting by other people, and the time frame in which the disclosure occurred. This may be of particular relevance to a child who has experienced sexual assault.
- responses by people in the person's family and broader social network in regard to belief, protection and ongoing support for them
- identifying impacts in regard to emotional, physical, behavioural and psychological issues
- identifying acts of resistance, how the client has been managing impacts, and what are their greatest struggles (e.g. flashbacks, nightmares, anxiety, fear, depression, etc.)
- identification of issues for family/significant others, and how these impact the client
- legal responses including police investigation, child protection involvement and possibility of future court procedures, including Criminal Court, Children's Court or Family Court
- identifying practical needs, including housing and income support, ongoing medical responses, protective measures such as increased security in the home, and subsequent referral to relevant services
- identifying the ways the victim is currently managing on a day-to-day basis and additional supports they may need and how these could be addressed (e.g. drug and alcohol, mental health, educational and safety issues)
- identifying the ways that the victim hopes ongoing work with the service could be helpful and/or what referrals are needed for other services and supports
- identifying and addressing immediate needs that have emerged from the assessment that cannot wait until the ongoing case plan ([Section 16.3](#)) is established (e.g. related to urgent safety and security needs, urgent mental health concerns, etc.).

### **16.3 Ongoing case plan**

Following a comprehensive assessment, the SAS counsellor will develop an ongoing case plan in partnership with the client and significant support people with relevant consents. This plan will consider:

- therapeutic goals relating to the impact of the sexual assault experienced by the client and other issues of concern that adversely influence ongoing safety and wellbeing
- identifying how these goals can be achieved in the short term and therefore what must take priority
- identifying immediate measures that can be used to achieve these goals
- identifying current risks to safety, including domestic and family violence, threats from other people, lack of security in their home, isolation, and chronic disruptions to daily living such as employment and attending school
- identifying strategies to address these safety issues, including referral for ongoing medical attention, formal contact with relevant people and agencies including Police, JCPRP, DCJ, housing, Centrelink, domestic and family violence services, Victims Services, schools and employers
- detailing the timing and length of ongoing sessions; contact agreements such as phone calls, texting or emails; nature and boundaries of the counselling relationship; and transport support or outreach agreements to ensure access.
- establishing the purpose and possible content of ongoing work together that seems of most value and what is needed from the SAS counsellor to best support the client. This work may include:
  - psychoeducation about the effects of sexual assault
  - developing skills such as grounding techniques, emotional regulation, meditation and mindfulness to assist managing symptoms
  - individual or family counselling ([Section 16.4](#))
  - client advocacy and casework ([Section 16.5](#)) and/or
  - group work ([Section 16.6](#))
- establishing an estimate of expected length of service, and a framework in terms of time periods to evaluate and review if there is a sense of progress in the work together.

### **16.4 Individual and family counselling**

SAS counsellors will adhere to the following best-practice principles in providing individual and family counselling in relation to sexual assault (adapted and added to from Kezelman & Stavropoulos, 2012):

- Provide a safe place for the client and prioritise safety.
- Be culturally respectful and include cultural beliefs, values and practices.

- Ensure client empowerment and collaboration, including providing choice and options regarding services and support available and being guided by the client about their stated priorities.
- Communicate and sustain hope, dignity and respect.
- Facilitate disclosure without overwhelming the client.
- Be familiar with a number of different therapeutic tools and models.
- View symptoms as adaptations.
- Have a broad knowledge of trauma theory and provide psychoeducation.
- Work together to demonstrate the client's own power, resources and decision-making.
- Support the development of adaptive coping strategies (self-care, distress tolerance strategies, and arousal reduction strategies).
- Support clients to understand and manage their thoughts and responses.
- Support the development of interpersonal and assertiveness skills.

Trauma-informed practice is a well-known and well-used term that has been infused into most health services. 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 acts of violence. Trauma-informed models of practice have evolved over time, but the three fundamental components remain: safety (internal and external), remembrance and mourning (more recently described as telling one's story) and reconnection (Herman, 1997; Bath, 2008). Although such models stipulate a process for recovery, the process is not linear and may be fraught with barriers, set-backs and stubborn challenges.

The sequence of a trauma model in regard to sexual assault, which also aligns with the ISTSS phase-based approach to trauma treatment (Cloitre et al., 2012), suggests that if a victim is able to experience sufficient **safety** (external and internal) to **tell the story** of their violence (or for ISTSS, review and appraise trauma memories), they will be able to rely on their **connection** to others to recover from the deleterious effects of the abuse they experienced (or for ISTSS, consolidate gains and transition out of therapy). This approach forms the basis of other models of practice including The Spiral of Healing Framework (Child Safety Commissioner, Victoria, 2009) and the Three Pillars framework (Bath, 2008 & 2016). While the three phases are complex processes and no individual will progress through them neatly or in a linear fashion, over the course of helpful interventions they are expected to '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, 1997, Chapter 8).

Although the above provides very broad guidance, the different therapeutic processes and modalities that workers use for individual and family counselling will be informed by each counsellor's personal and service practice frameworks; evidence of the effectiveness or otherwise of different models of counselling (noting that the body of evidence on this is limited); the demographics in which the SAS is situated; the competing demands for services, which includes crisis and longer term responses; and the differing needs of clients across the lifespan and across different social contexts. The choice and effectiveness of any specific therapeutic interventions will be determined by:

- the priorities of the client, their goals for counselling, and their preferred way of working
- the extent and complexity of the sexual and other types of violence they have been subjected to and residual legacies of emotional, psychological, physical and relational harm
- the unique lived experiences of the client including their social identity (age, culture, sexuality, gender ability) and ongoing risks to their emotional, economic, physical and relational safety and wellbeing
- the constrictions placed on them due to accompanying struggles with drug and alcohol misuse, mental health, self-harming behaviours, debilitating anxiety, and current subjection to interpersonal violence and abuse
- the quantity and quality of external support provided by others in their personal, family, social and community networks, recognised as one of the most significant factors that enable people to move on from the violence they have experienced.

The exception to this choice of interventions is that, at this time, SASs are not to use hypnosis, any technique that could be considered hypnosis or eye movement desensitisation and reprocessing (EMDR) in the course of their therapeutic interventions with people who are, or may become, involved in the legal process. This is due to the Office of the Director of Public Prosecution's (ODPP) Prosecution Guideline 27 that the Prosecution will not tender evidence where its subject matter was recalled for the first time under hypnosis/EMDR.

### **16.5 Client advocacy and casework**

Advocacy refers to a wide range of activities to promote, protect and defend victims' and survivors' human rights and their rights to services and information. It may involve assisting victims and survivors to express their own needs, access information, understand options and make informed decisions. (Royal Commission, 2017, Vol. 9, p. 22)

Client advocacy and casework, which may also be known as care coordination, are critical components of the SAS response and will be undertaken by SAS counsellors as a key part of ongoing therapeutic interventions. This is particularly because, to be effective in responding to this client group, addressing the client's 'state of affairs' can be equally as important as addressing their 'states of mind' (Scott, 2013).

Client advocacy seeks to assist the client group to navigate and access information and services, to ensure their needs are appropriately met during their contact with the complex interagency system involved. Victims of sexual assault and their families/significant others are not commonly familiar with this system, or aware of their rights and entitlements or how to meet their needs within it. It is therefore important that they have an advocate to provide information about their rights, entitlements, and how to best navigate the system to meet their needs. Client advocacy may be informal (e.g. seeking a particular service for a client from another agency) or formal (e.g. attending or coordinating interagency meetings and case planning for a client). Client advocacy may also overlap with the broader psychosocial support role, such as where the SAS counsellor attends a police interview with a client as a support person.

All forms of client advocacy require consent of the client and care must be taken to protect client confidentiality (NASASV, 2015, p.18). Advocacy can empower victims by providing safe opportunities for them to exercise control over decisions and to assist them to navigate the

complex range of services they may need. NASASV (2015) argues advocacy and support services can:

- Help victims of sexual abuse access resources and relevant information.
- Enable victims to meet with other victims of sexual abuse and receive positive support by breaking secrecy and isolation, sharing stories that hold commonalities, and enable connections with others.
- Aid in recovery from trauma by providing psychoeducation, develop problem-solving skills and enhance personal agency.
- Decrease the risk of further abuse.
- Promote systemic improvements to service responses.

Although SASs don't usually provide case management (coordination of individual client care with the aim of improving client access and service provision), they will nevertheless provide casework,<sup>39</sup> care navigation and care coordination particularly as it intersects with their role in client advocacy identified above. Client advocacy and casework activities may include (but are not limited to):

- attending a police or other criminal justice system (e.g. ODPP) meeting as a support person for the client
- attending and/or providing input into case meetings and other case coordination processes to inform activities to help enhance the safety, welfare and wellbeing of the client
- attending and/or providing input into meetings or activities, such as Safety Action Meetings, that concern violence, abuse and neglect or other issues related to the client themselves or their family (e.g. parent/s) that may impact on their safety, welfare or wellbeing
- help the client negotiate the service system to meet agreed goals and identified needs — e.g. support attending social housing appointments, writing support letters
- actively advocating with another service or system (e.g. another Health service or DCJ) for them to intervene or provide services to ensure the needs, rights or entitlements of a particular client/s are met. This may include activities that are formal (e.g. a letter) or informal (e.g. a phone call). It could also include 'warm' referrals such as attending the first appointment with a mental health worker who will assist the client or parent/carer to address ongoing mental health issues that are negatively impacting on their safety, health or wellbeing
- assisting clients to better negotiate multiple services and service systems by, for example, actively collaborating and providing a seamless response to the client in partnership with other relevant services. This might include, for example, advocating for and coordinating joint assessments between one or more services, or sharing information from standardised assessment tools (with the appropriate consents) to minimise duplication or over-assessment.

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<sup>39</sup> Note: While casework involves a range of activities to support a client in having their needs met, it does not require the level of coordination and responsibility by an individual worker that case management requires (see also outline of casework and case management in the glossary).



## **16.6 Group work**

Group work can be an integral part of providing additional counselling options for victims of sexual assault. SASs will provide group work, where resources allow, according to the identified needs of clients currently attending or referred to the service. SAS group programs will (adapted from NASASV, 2015):

- Have procedures that address aims and objectives, planning, eligibility and suitability of people for a group, rights and responsibilities of group members and SAS counsellors, identify confidentiality requirements and limitations, cross-agency collaboration, and evaluation.
- Be facilitated by qualified SAS counsellors who have group facilitation skills.
- Have in place sufficient intake and assessment procedures to ensure that participation in the group is appropriate for the client's needs.
- Ensure group participants are aware of their rights and responsibilities of participation, including confidentiality, consent, and terms of service.
- Receive written consent to participate from each participant.
- Have procedures in place to follow up on the safety and wellbeing of group participants during and between group sessions.
- Provide participants the opportunity to evaluate group processes and outcomes.
- Have clear guidelines in relation to confidentiality and consultation between practitioners where the client is participating in counselling and group work concurrently.
- Record information about the group such as type of group, number of participants, session content and resources used, and evaluation processes and outcomes, and record group attendance in the client's SAS record.

## **16.7 Review**

Ongoing therapeutic interventions are to be evaluated on an ongoing basis using a range of different evaluation strategies. This may include clinical reviews, client base evaluations, feedback from other services, group work formal evaluations and consultation processes with client groups.

As noted by NASASV (2015) there are several challenges when measuring client outcomes and effectiveness of interventions. They include:

- Client progress is not linear and is prone to day-to-day disruptions and stressors, and extends over the timeline of a person's life and beyond the relatively limited time span of engagement with a service.
- There is potential bias and shortcomings in relying on practitioner-client review sessions alone, given the power differential that exists, existing vulnerabilities for a client and a tendency to elevate practitioner's expertise above their own.
- There are limited peer-reviewed randomised controlled trials for effectiveness of counselling interventions in regard to alleviating the impacts of sexual abuse.



- Counselling interventions cannot be skewed as a “one size fits all” approach and any assumption that what may be successful for one client group will achieve the same results for a different client group is flawed.

SASs are to consider the following when developing local strategies and approaches to review of clinical services:

- Use an evidence-based (validated) evaluation tool appropriate to the therapeutic interventions used and that enables collating across the service (a useful resource on different evaluation measures can be accessed through *Improving Access to Psychological Therapies* (Department of Health, 2012)).
- Measure progress against the individual counselling plans and goals agreed with the client.
- Review the client’s goals regularly throughout the counselling intervention and amend according to changing needs as identified in regular case reviews.
- Undertake file audits by appropriately qualified personnel.
- Implement supplementary evaluation strategies, including client feedback sessions, review of emerging evidence in the literature, reflective practice and clinical supervision.

## **16.8 Closure and conclusion of contact**

SASs will ensure that clients who have completed any interventions provided by the service (referral, assessment, counselling, advocacy, group work) are further encouraged to access ongoing support and are provided with information and options concerning additional services.

In planning for the reduction and conclusion of contact with a client, the SAS counsellor will:

1. Undertake a review of the goals that were initially set down in the case plan between the SAS counsellor and the client. This review is to ensure that issues have been adequately addressed and that all relevant information and resources required have been offered.
2. Address any outstanding medical or legal issues prior to completion of contact, or arrangements will be made to address these issues at a later date, e.g. returning for court preparation.
3. Advise the client they can re-contact the service in the future, if they wish to do so.
4. Consider appropriate referral to other services as required (e.g. mental health services, drug and alcohol services).

Following case closure, a summary will be filed on the SAS counselling record which will include:

- date of initial allocation
- overview of presenting issues assessment information
- nature of services provided
- number of sessions of counselling
- clinical evaluation of the effectiveness of interventions
- reason for closure.

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## **16.9 Working with significant others**

While significant others of people who have experienced sexual assault are a client group for SASs, ongoing interventions with this group are usually less extensive than for primary victims. Sexual assault is often a crisis for the victim's family, partner and friends, and they may also be managing their own struggles and uncertainties resulting from their discovery that someone close to them has been sexually harmed. They therefore need and are to receive support, not only for their ongoing wellbeing but also to assist their ability to provide a well-informed, supportive response to the victim.

At times, family members/significant others will contact SASs about someone who has disclosed to them they have been sexually assaulted. SASs will provide support and information to those family members or friends/significant others in those instances. Where appropriate, counselling with children and young people will also be family-focused, to enable parents/carers and children to work together to address the impact of the sexual abuse and maintain safety. Services will encourage participation by parents/carers in the counselling process where appropriate to ensure they are actively involved in the child's or young person's recovery. This will occur through joint counselling processes and family work where possible (see also child/young person-centred and family focused practice in [Appendix 4](#)).

## 17 COURT PREPARATION, COURT SUPPORT AND LEGAL REPORTS

### 17 Court preparation, court support and legal reports: summary

- Court preparation, court support and the provision of legal reports, particularly in the prosecution of sexual assault offences, is a key part of the SAS service model.
- SASs are most likely to provide court preparation and court support in three main contexts: the criminal justice system, Family Court, and Children's Court.
- SAS staff will have up-to-date information and training in quality report writing and will ensure all legal reports prepared are clear, accurate and comprehensive.

#### 17.1 Criminal justice system

Engaging with the legal system, including giving evidence and making other court appearances, can be extremely traumatic, re-traumatising and confusing for people who have experienced sexual assault. Equipping a sexual assault victim and their family/significant others with information, appropriate skills and support is therefore an essential role for SAS counsellors. This can assist victims understand the complexities of the court process, thereby increasing their feelings of control about the situation and reducing the impact of the sexual assault. SAS counsellors will:

- Provide information about the criminal justice system relating to sexual assault.
- Provide court preparation and support for people giving evidence regarding sexual assault.
- Use accredited court preparation material when preparing clients to give evidence in court. This material includes the [Justice Journey](#) website, along with the associated DVD, factsheets and booklet, and the ECAV resource [Nothing But The Truth](#).
- With the appropriate consent, liaise with the ODPP and, if relevant, the Witness Assistance Officer (WAS) to ensure that accurate, current information on matters concerning the court hearing is made available to the client.
- Negotiate with the victim and other agencies, with the appropriate consent, to determine the appropriate people to be involved in court preparation and support.
- Be a support person for a person who has experienced sexual assault when they meet with the ODPP and/or in preparing for court (such as watching/listening to the recording of their police interview alongside the ODPP legal officer). **Note:** *this is only to happen when the SAS counsellor is not giving evidence in the same trial (e.g. first disclosure evidence).*
- Travel within and outside of the district/network where required to support a client in court with the support of their district/network to undertake this travel.
- Provide post-court debriefing regarding the impact of court processes and outcomes.

These services will be provided in consultation with the WAS of the ODPP where appropriate. Particularly where WAS is already providing services, it will likely be unnecessary for the SAS counsellor to provide them as well. They may, however, need to work collaboratively with WAS, with the appropriate consent, to advocate for the client to receive the specific services they need.

## **17.2 Family Court**

It is often the most vulnerable families with the most complex needs who are turning to the family law system, but the family law system is not well equipped to deal with families experiencing sexual assault, domestic and family violence, or child abuse and neglect. Difficulties for victims when negotiating this space include:

- The protection of children/young people exposed to post-separation domestic and family violence (which may include sexual assault) is limited by the jurisdictional gap between the statutory child protection and the family law systems, often with expert child protection reports assessing risks to children generally not available to inform the Family Courts' decision-making (Laing, Heward-Belle, & Toivonen, 2018).
- Family Courts' lack of access to the evidence required to make decisions in the interest of children/young people's safety in a system designed to resolve parenting disputes where there is a reliance on the parents providing and presenting the evidence (Family Law Council, 2015).
- Families involved in family law proceedings where child protection concerns were raised, were not primarily those already known to state child protection services, but families where violence and abuse occurred or was disclosed in the context of relationship breakdown (Brown, Frederico, Hewitt, & Sheehan, 1998; Fehlberg, Kaspiw, Millbank, Kelly & Behrens, 2015; Kaspiw et al., 2015), meaning no other services are involved and evidence is hard to obtain.
- A number of family law clients (either at the Family Court, family dispute resolution centres, or mediation centres) who have experienced domestic and family violence, which may include intimate partner sexual assault or child sexual assault, are not assessed as domestic and family violence-affected. Some are not being asked while others choose not to disclose when asked (Kaspiw et al., 2015).
- Social justice gaps, which can affect children's safety, also arise due to resource implications for each system. While the state funds child protection services (public law) interventions, parents fund litigation in the federal (private law) system, which may be a barrier to a parent with concerns for children's safety pursuing a matter through to a judicial determination (Laing et al., 2018).
- Blaming the mother for the father's abuse of the child or children (Jeffries, 2016).
- Courts are not always well-informed on issues of memory, retraction, or child's affection for a perpetrator (Powell, Roberts & Guadagno, 2007; Richards, 2009), which may impact on outcomes for the child that could place them at further risk (Neoh & Mellor, 2009).
- For younger children, the legal system and child protection systems may place more value on the rights of the parent/adult than the rights of young children unable to make a statement that meets the requirement of beyond reasonable doubt due to their age, language limitation, memory, influence of others or because investigators have minimal early childhood experience or training (Powell, 2005).

SAS counsellors will acknowledge the above barriers when working with victims of sexual assault and their families navigating the family law system. Actions to continue to support victims through the process are critical and may include:

- providing a non-judgemental, empathetic and supportive approach to help mitigate any negative experiences of the family law space
- where there is an active contested family law court case, engaging cautiously and consider providing support to the protective parent, but not seeing the child directly at this point if it may damage the credibility of the protective parent or any future disclosure the child may make
- focus on the safety of any children and young people involved in the family and any relevant risk existing or arising in the context of family law matters
- working collaboratively with other service providers and, in particular, advocating for relevant information from the child protection system being actively considered in family law matters
- advocating for clients within the family law system as appropriate
- providing court preparation and support where appropriate.

In addition, SAS Counsellors may specifically need to be conscious and careful of:

- managing the child's sense of confidentiality and need to respond to court requests for opinions
- managing the dynamic of a parent seeking sexual assault counselling in the context of high-level parent conflict and using counselling sessions as a place to encourage the child to disclose
- engaging a child specifically around terms of their trauma history while they are trying to survive the crisis of engagement with the Family Court.

### **17.3 Children's Court**

Intervention by the state in a child or young person's life to determine if they can remain with their family is one of the most difficult situations a family can face. Regardless of the circumstances that led to statutory intervention, maintaining the best interest of the child or young person while balancing their safety and connections with parents and other family members is highly emotive and contentious. Children, young people, parents and carers can find the process adversarial, distressing and anxiety-provoking, which can exacerbate previous traumatic experiences.

SAS counsellors can play a unique role in supporting children and young people and their parents/carers and families through this process. The nature and extent of this support will vary according to circumstances and when the court process may take place. SAS counsellors may:

- Provide information to the Court to assist decision-making, both to outline the past harms that the child/young person has experienced as well as the likelihood for change of the parent/s behaviour or circumstances that led to the intervention. Care is to be taken here to help support the Children's Court processes in the best interests of the children/young people while also not compromising the role of SAS counsellors in providing therapeutic interventions and support.
- Provide advocacy, casework and psychoeducation to support a child/young person and/or parents/carers through the Children's Court processes.
- Support children/young people and carers when assessment and intervention suggest that the child/young person is best placed away from their family.

## **17.4 Legal reports**

SASs will ensure that both psychosocial and medical and forensic staff have up to date information and training in quality report writing and that all legal reports prepared are clear, accurate and comprehensive. SAS will:

- Provide legal reports on request from a person who has received a counselling or medical response from the SAS where the report writer has the appropriate qualifications and/or accreditation to do so in the circumstances.
- Undertake further interviews with the victim, if necessary, to provide a clear and accurate assessment in a legal report.
- Where a person requests a report prior to legal proceedings being finalised, take care not to disclose communications made by the client that may result in a waiver of the client's privilege. Legal advice will be sought if any uncertainty exists.
- Consult with Victims Services about what information is required, with the appropriate consent, on receipt of a request for a report in relation to a victim's application for Victims of Crime recognition payment where the victim has not made a report to NSW Police or DCJ.
- Provide people the opportunity to review their reports or provide information about how to access reports where appropriate (e.g. in the case of Expert Certificates, this would be through NSW Police or ODPP).
- Ensure legal reports prepared are clear, accurate and comprehensive. It is good practice for reports to be reviewed by a senior clinician prior to being submitted.
- Have local procedures in place in cases for external referrals for assessment and report writing. These may include for victims who have not received counselling or medical responses from the SAS, where additional material may need to be included in a report, or where the SAS has no staff with the appropriate qualifications or accreditation required.

SAS staff required to provide a report to a NSW Court will ensure they have read the *Expert Witness Code of Conduct* in Schedule 7 of the [NSW Uniform Civil Procedures Rules 2005](#) and agree to be bound by the code.

### **17.4.1 Medico-legal reports**

Providing medico-legal reports to support the prosecution of sexual assault criminal matters is an important part of medical and forensic services to support victims of sexual assault provided by SASs and is therefore the responsibility of the district/network to provide. Information about Expert Certificates and other medico-legal reports prepared by medical and forensic examiners is at [Section 15.14](#).

### **17.4.2 Victim Impact Statements**

Clients have a right to be advised of the advantages and disadvantages of Victim Impact Statements (VIS) so that they may make informed decisions. SASs will provide clients with accurate information regarding VIS and support the client with regards to their decisions about a VIS. With regard to VIS, SASs will:

- Provide clients with accurate information regarding VIS.



- Ensure that all SAS counsellors are trained and aware of current information in the preparation of VIS.
- Discuss with the client who is the most appropriate person to prepare the statement when a VIS is requested.
- Inform victims that they may be cross examined on their VIS and that the media may gain access to the VIS through the court registry and may report on any content that is read out or referred to in court.
- Ensure that SAS counsellors liaise with the ODPP prior to writing a VIS.
- Use the Victims Services [Victim Impact Statement Information Package](#) as a guide when preparing or supporting the preparation of a VIS.
- Inform clients that VIS will not be prepared prior to conviction of the offender, and that clients are entitled to write their own VIS and can seek guidance to undertake this task from the ODPP, noting there may be disadvantages in this approach.

## 18 SYSTEMS ADVOCACY

### 18 Systems advocacy: summary

- Systems advocacy is a key part of the SAS response and may include a range of activities whereby the SAS seek to influence policy or resource distribution.

Advocacy work can be practiced with individual clients (or a client group) or at a systems level. Although there are several forms of advocacy, they do not stand alone and best to work together. For example, client advocacy has the 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, 2015, p.18). Information about advocacy for individual clients is provided in [Section 16.5](#), while information about systems advocacy is provided below.

Systems advocacy, which may also be known as systems change, 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' (NASASV, 2015, p. 18). It is usually informed by the experiences of the client group and seeks to bring about changes where a number of clients may have had similar negative experiences of particular systems, processes or practices. This may include advocacy for legislation, policy or practice change to positively impact on the people who have experienced sexual assault as a whole. The breadth and depth of SAS work provides a unique opportunity to provide insights into patterns and a platform from which to provide changes to improve how our systems respond.

Examples of systems advocacy and systems change that SASs may engage in include, but are not limited to:

- raising the profile of sexual assault, including by providing expert advice on the issues in media or other public forums (in accordance with NSW Health policy and local approvals processes)
- providing respectful and constructive feedback and working with intra and interagency partners to improve their policies, procedures and practices concerning people who have experienced sexual assault. This may include participation in, and contribution to, internal NSW Health policy development and implementation concerning these issues.
- convening, participating in, sharing information, and advocating systems change in intra and interagency groups/meetings such as: NSW Health VAN services managers' meetings or forums, and SAS committee meetings
- writing submissions or providing input into submissions for legislative or other systems change (in accordance with NSW Health policy and local approvals processes)
- advocating for additional funding, appropriate evidence-based programs, service expansion or service realignment to address service gaps for people who have experienced sexual assault.

## 19 PROFESSIONAL CONSULTATION AND TRAINING

### 19 Professional consultation and training: summary

- SAS will provide consultation to other professionals, both within and outside the health system, to help facilitate access to the SAS, support interagency collaborations, and strengthen the capacity to work effectively in clinical settings other than SASs with people who have experienced sexual assault.
- SASs will provide informal training and education for health professionals, other workers, and other agencies and interagency partners to increase the ability, confidence and capacity of professionals to respond in a trauma-informed manner to people who have experienced sexual assault.

Prevention of violence occurring or reoccurring and further harm is central to the public health approach that underpins NSW Health's responses to sexual assault. The nature and scale of sexual assault and the sometimes inadequate responses to victims of sexual assault from health, justice and social service systems necessitate interventions with professionals and not just individual clients. The Royal Commission (2017) highlighted the significant role that sexual assault service providers have in enhancing the service system to respond effectively to trauma that survivors of sexual abuse hold. SASs have a responsibility to address service gaps and support mainstream services to respond effectively using trauma-informed approaches to people who have experienced sexual assault beyond those clients accessing SASs.

#### 19.1 Professional consultation to other services

SASs may provide consultation to other professionals, both within and outside the health system, to help facilitate access to the SAS, support interagency collaborations, and strengthen the capacity to work effectively with people who have experienced sexual assault in clinical settings other than SASs. Such consultation is a key element of SASs, because the prevalence of sexual assault is so common in the community that: 1) it is not possible for a SAS to respond to every person who has experienced sexual assault, and 2) many people who have experienced sexual assault will present to many different types of NSW Health services and are to be provided those services in ways that are sensitive to all of their needs, including their experience of sexual assault.

Consultation can include activities that are formal (e.g. providing clinical supervision) or informal (e.g. advice over the phone or ad hoc debriefing about a particular case). Functions of consultations provided by SASs may include:

- to assist case analysis and problem solving with other workers
- to build capacity in other services through sharing knowledge and encouraging reflection
- to debrief health staff (e.g. in EDs) where they have provided treatment related to sexual assault
- to support collaboration, such as where one service has the relationship or mandate with the client/patient while the SAS may have specialist expertise and knowledge that could contribute to effective work with that client/patient.

As a general principle, if consulted about an area of practice that is outside a SAS staff member's area of expertise, it is their responsibility to seek other options. SAS staff are not required to be subject matter experts in all areas of violence, abuse and neglect. However, they are responsible for identifying and referring on to people with relevant expertise when needed.

While case responsibility remains with the worker consulting the SAS, the SAS staff member is responsible for the quality of the consultation, within the parameters of the information provided. Consultation commonly involves making recommendations and suggestions for consideration, and it is up to the person working with the client/patient to decide whether or not to act on that advice (Berry Street, 2015). If SAS staff are concerned about the client/patient's safety, however, they will discuss these concerns with the worker seeking consultation, document this in their notes, and adhere to normal reporting requirements ([Section 4](#)) where they have the necessary identifying information.

During a consultation, identifying information about an individual client or family will only be shared with the SAS with the appropriate consents, or in accordance with information sharing provisions in legislation and policy ([Section 22.2](#)). While the consultee is responsible for the recording of advice received on their organisation's client file, the SAS will have local procedures in place for consultation (including recording requirements) and the SAS staff member will keep a record of the consultation for quality assurance purposes. This record will enable the SAS to record the details of the consultee (but not the client/patient except with appropriate consent), the nature of the consultation, including the time taken to provide the consultation, and the outcome.

When providing consultation, it is important to clarify expectations and not make assumptions about the other worker's context, especially if the client/patient or consultee is from a different cultural background, and ensure any consultation is culturally respectful.

SAS staff may also be in a unique position to provide support, debriefing, and/or advice, including referral, for other professionals who are triggered by the sexual assault issues they are consulting with the SAS on. There are many professionals, including health workers, with their own histories of sexual assault. SAS staff need to be sensitive to this in providing consultation services to professionals and provide appropriate support and referral in situations where professionals consulting them may personally be in need.

## **19.2 Training and education to other services**

Sharing professional knowledge and skills in the area of sexual assault is an important step in ensuring that all agencies and the community can be responsive to the needs of people who have experienced sexual assault. SASs will therefore provide informal training and education<sup>40</sup> for health professionals, other workers, and other agencies and interagency partners to increase the ability, confidence and capacity of professionals to respond in a trauma-informed manner to people who have experienced sexual assault.

The content of training and sessions offered will respond to specific needs and reflect current evidence-informed research and clinical practice. Training provided by SASs will usually include:

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<sup>40</sup> This refers to training and education that is not part of a formal, e.g. an accredited, training course or educational qualification.

- information about SAS response, including intake and referral to support appropriate intra- and inter-agency collaboration
- accurate information on the dynamics, extent, effects and implications of sexual assault
- facilitation by qualified practitioners who maintain a current and comprehensive understanding of issues related to sexual assault, trauma and intervention
- facilitation within a safe, respectful learning environment that caters for participants at various stages of personal and professional development.

Where professionals, agencies and interagency partners are interested in formal training or education, the SAS staff will refer them to appropriate specialist formal training courses, which may include the NSW Health [Education Centre Against Violence](#) (ECAV).

SAS managers will:

- Liaise with district/network management to identify training needs and training strategies with regard to sexual assault to ensure that relevant district/network staff are trained.
- Facilitate access to specialist formal training in the district/network from accredited training bodies, including [ECAV](#).

## 20 COMMUNITY ENGAGEMENT, EDUCATION AND PREVENTION

### 20 Community engagement, education and prevention: summary

- Prevention of sexual assault refers to strategies that seek to prevent violence from occurring or re-occurring, as well as to prevent or minimise the harm caused by the violence. There are three types of prevention work: primary, secondary and tertiary.
- SASs engaged in primary prevention interventions will draw on the guidance from the best available evidence as outlined below.
- Community education campaigns and strategies for broader population groups, including topics such as respectful relationships, gender drivers of violence, or information-based education (such as legal or service advice, what violence looks like) are also an important part of SAS prevention work.
- SASs will contribute to, and advocate for, continued research, practice and policy information to inform responses to sexual assault where resources allow and in accordance with relevant legislative and NSW Health policy requirements.

Engagement and education with local communities over time in a way that is culturally appropriate, observes appropriate protocols, and is responsive to community input and feedback is important to facilitate equity of access to services. It can also help to improve the overall community response to victims of sexual assault.

SASs will conduct community education and prevention programs that accommodate a range of experiences of sexual assault relevant to the communities in which they are operating, including addressing the needs of particular communities and population groups, such as Aboriginal communities, people with disability, young people, culturally and linguistically diverse communities, and LGBTQI communities. This engagement and education may include a range of activities such as having a stall at local events, building relationships with elders or community leaders, or running or participating in specific interagency prevention or community education activities, programs or events.

### 20.1 Types of prevention work

Prevention of sexual assault refers to strategies that seek to prevent the violence from occurring or re-occurring as well as to prevent or minimise the harm caused by the violence. The socio-ecological model (see Figure 1 in [Section 1.2](#)) is helpful in understanding the different levels where prevention work can take place: the individual, relationship, community and societal levels.

Health, family, and community settings (e.g. hospitals, community health, child and family health, and SAS) are 'priority settings for action' in prevention work because workers in these settings have significant relevant practice expertise and knowledge. They are also in a position to influence the social norms, organisational practices and institutional structures that can drive change. They historically have a strong work practice in the community development work and cross-sector initiatives that are a strong focus in prevention work (Our Watch, 2015).



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

### **20.1.1 Primary prevention**

Primary prevention aims to tackle the underlying social conditions that allow sexual assault to occur in the first place, primarily gender inequality, but also including: norms, practices and structures that are in place in current society (Our Watch, 2017). Primary prevention work can be delivered through community wide intervention strategies aimed at preventing the occurrence of sexual assault through facilitating behaviour change in the broader community.

Primary prevention is not about working with people at risk of either perpetrating or experiencing violence. Rather, it works with all people, across all levels of society, to change and transform the social context in which violence flourishes (Our Watch, 2017).

[\*Change the story: A shared framework for the primary prevention of violence\*](#) (Our Watch, VicHealth & ANROWS, 2015) outlines the five areas of social change that are required to prevent violence against women and their children before it occurs, which are also applicable to sexual assault generally, and, in particular, noting the gendered dimension of sexual assault ([Appendix 1](#)). These areas are:

- to challenge condoning of violence against women (or sexual assault)
- to promote women's independence and decision-making in public life and relationships
- to foster positive personal identities and challenge gender stereotypes and roles
- to strengthen positive, equal and respectful relations between and among women and men, girls and boys
- to promote and normalise gender equality in public and private life.

Best practice prevention work must be inclusive of those who experience significant disadvantage and discrimination, and therefore be responsive to differing needs and contexts. Consideration of priority populations and a focus on an intersectional approach to prevention work is critical (Sections [3.5](#), [11](#), & [21](#) and [Appendix 5](#)).

### **20.1.2 Secondary prevention**

Secondary prevention focuses on high-risk groups/individuals and aims to reduce the risk of sexual assault and/or to prevent reoccurrence of sexual assault. Examples of these types of interventions include working with homeless young people, those incarcerated, or those who have experienced sexual assault in the past.

### **20.1.3 Tertiary prevention**

Tertiary prevention involves providing therapeutic services to people with existing traumas from sexual assault, with the aim of minimising the impact of the violence, support recovery, and minimise and prevent subsequent health consequences of sexual assault. Examples of interventions include the provision of client services by SASs, awareness-raising during counselling, engaging with family/support networks, effective referral to other support services, interagency collaboration to address co-existing needs, and offender programs.

## **20.2 Primary prevention interventions**

The public health approach requires collaboration and integration across many sectors and disciplines to prevent sexual assault. In practice this involves four distinct steps (WHO, 2004, p.5):

1. Define the magnitude, scope, characteristics and consequences of such violence through systematic collection of information.
2. Identify and research the risk and protection factors that increase or decrease the likelihood of violence.
3. Determine what works in preventing violence by developing and evaluating interventions tailored to the demographic and socioeconomic characteristics of the groups in which they are to be implemented.
4. Implement effective and promising interventions in a wide range of settings and evaluate their impact and cost-effectiveness.

Primary prevention interventions must:

- Aim to achieve behaviour change and not address community risk-management strategies such as 'stranger danger' programs.
- Target men and women and include the broader community, including strategies to engage parents/carers, families and communities.
- Target a range of delivery locations, including schools.
- Use a range of practices to respond to geographical and cultural differences across Australia.

SASs in partnership with other district/network programs (e.g. population health, priority populations) will undertake primary prevention activities, drawing on the following guidance (adapted from Carmody, Evans, Krogh, Flood, Heenan & Ovenden, 2009 and Our Watch 2015 & 2017):

- Implement prevention strategies in line with relevant national and state frameworks and in collaboration with local communities and population groups.
- Use an explicit gender analysis and focus on changing the gendered drivers and cultural norms and values underpinning sexual assault.
- Use coherent conceptual approaches to program design, development and delivery that draw on research evidence from international and local literature and practice knowledge and which plan for long-term sustainability of effective initiatives.
- Incorporate inclusive, relevant, trauma-informed and culturally sensitive practices, considering diversity and individual experiences of violence and the compounding effects of disadvantage for some victim/survivors. Some techniques that have demonstrated effectiveness include: direct participation programs, community mobilisation and strengthening, organisational development, communications and social marketing, and civil society advocacy.
- Ensure sexual assault prevention education programs are delivered by well prepared and supported professionals or peer educators.

- Establish mechanisms to respond to disclosures from victims/survivors and perpetrators who may be identified through their engagement with a prevention program.
- Use effective evaluation strategies and develop an evaluation plan focused on measuring changes related to the drivers of violence. In particular, SASs are encouraged to collect adequate data that indicates the effectiveness of a program in achieving its stated objectives, leads to recommendations for refinement and/or future rollout, and gauges its impact on participants and contribution to primary prevention.
- Establish partnerships across sectors and between violence prevention/gender equality specialists and 'mainstream' organisations.
- Share information and facilitate transparent reporting and shared learning.

### **20.3 Community education**

Community education campaigns and strategies for broader population groups, including topics such as respectful relationships, gender drivers of violence, or information-based education (such as legal or service advice, what violence looks like), are also part of prevention work. Community education strategies are designed to support and build the capacity of relevant service providers, workers and community members to understand the impacts of sexual assault and respond appropriately. SASs will provide local community education activities to enhance prevention and public awareness of issues about sexual assault and other forms of violence, abuse and neglect and to support statewide and national community education initiatives. In providing community education SASs will:

- Consider local needs.
- Aim to increase community awareness about the incidence, dynamics and impacts of sexual assault, the needs of people who have been sexually assaulted, and available services and resources through accurate information.
- Take into account local cultures and cultural protocols and provide multilingual information, including the use of interpreters to provide information sessions, where possible and available.
- Use a variety of media appropriate to the local context.
- Collaborate with local community services and other agencies where appropriate.
- Address safety issues and ensure support services are available for participants.
- Ensure that participants are aware of confidentiality requirements and limitations.
- Evaluate community education and development programs and revise programs in response to these evaluations.
- Develop new content and sessions in response to specific community needs and to reflect updates in research and clinical practice.

[ECAV](#) has developed various resources to assist in providing community education.

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## **20.4 Research and evaluation**

SASs will contribute to advocate for continued research, practice and policy information to inform responses to sexual assault. In particular, SAS will:

- be evidence-informed and incorporate the findings of research into their service delivery and practice as appropriate
- participate in and contribute to research on sexual assault where resources allow and where it has fully assessed that the research is ethical, appropriate and meets relevant legislative and NSW Health policy requirements including [Research — Ethical & Scientific Review of Human Research in NSW Public Health Organisations](#) and [Research — Authorisation to Commence Human Research in NSW Public Health organisations](#)
- refer requests for research to the SAS manager (psychosocial), the medical director (medical and forensic) and the district/network Ethics Committee to ascertain the need for, and the level of, ethics approval required
- liaise with their district/network Ethics Committee to ensure the SAS is consulted about proposal relating to sexual assault.

## 21 WORKING WITH ABORIGINAL<sup>41</sup> PEOPLE AND COMMUNITIES

### 21 Working with Aboriginal people and communities: summary

- SAS staff need to understand the context of violence against Aboriginal people; the barriers they face in accessing services; and their resilience and deep connection to culture, kinship, family and history, and actively address injustice and support resilience and healing in responses to sexual assault.
- To achieve this, SASs will action the following four key areas :
  1. cultural safety and cultural competence
  2. community engagement
  3. Aboriginal cultural consultation
  4. supporting the Aboriginal workforce.
- Each SAS will develop an Aboriginal Action Plan (template at [Appendix 9](#)) and complete this as a part of normal service planning, at a minimum annually.
- The development of culturally safe and culturally competent health services is a key strategic direction of the [NSW Aboriginal Health Plan 2013-2023](#) and is consistent with the [Cultural Respect Framework 2016-2026 for Aboriginal and Torres Strait Islander Health](#).
- Engagement with local Aboriginal communities is a core part of SAS work and is essential in achieving positive outcomes for the clients and communities.
- SASs will develop local procedures for Aboriginal consultation in collaboration with Aboriginal Health staff and local Aboriginal services, which will include recording this on client records (templates at Appendices [10](#) & [11](#)).
- Developing, supporting and learning from an Aboriginal SAS and broader health workforce is vital for effective work with Aboriginal clients and communities.

NSW Health recognises the impact of racism, colonisation, white privilege and cultural bias, social determinants and oppression on Aboriginal people and their families and communities, and the injustices Aboriginal people and workers face in using or working in mainstream services. Aboriginal people are impacted by issues such as the over-representation of Aboriginal children on child protection orders and in OOH, threatened closure of remote communities, systematic violence and control of whole communities, over-representation in the criminal justice and prison systems, poverty and income management policies and intergenerational trauma. These impacts are recognised in the [NSW Aboriginal Health Plan 2013-2023](#), which states the barriers faced by Aboriginal people in using mainstream services are a result of systemic racism.

It is the responsibility of SAS staff to understand the broader contextual experience of Aboriginal people, how this informs their individual experience of sexual and other violence, and the barriers to accessing services (see [Appendix 8](#) for a brief summary). This includes an understanding of the strong cultural history and resilience of Aboriginal people as a foundation upon which to build

<sup>41</sup> The term 'Aboriginal' is used in this policy and procedures to describe Australia's First Nations people in recognition of the context of this document being for NSW. The term 'Aboriginal and Torres Strait Islander' is used when citing sources such as from national organisations or national statistics.

further efforts to improve Aboriginal health and wellbeing. Addressing injustice and supporting resilience and healing in response to sexual assault requires this prerequisite understanding.

NSW Health is committed to supporting SASs to actively address injustice and support resilience and healing for Aboriginal people in responses to sexual assault. Aboriginal Action Plans provide a structure for SASs to plan and implement action that allows for local expertise, knowledge and relationships to build cultural competent services. NSW Health recognises that this will only be achieved through respectful relationships and leadership of local actions by Aboriginal communities and SASs. [ECAV](#) provides resources, support and qualification pathways that can assist in the development and implementation of Aboriginal Action Plans.

Some guidance on these is provided below, but relevant training will also inform practice. All NSW Health staff members are required to complete the eLearning and face-to-face components of [Respecting the difference: An Aboriginal cultural training framework for NSW Health](#). Core training for SAS counsellors, managers and clinical leads includes ECAV run *IN-1018 Developing culturally safe trauma-informed practice in Aboriginal communities*. SAS staff will also be guided in this work by the forthcoming NSW Health *Aboriginal Family Wellbeing and Violence Strategy 2019-2023*.

## **21.1 Addressing injustice and supporting resilience and healing**

Trauma can impact on families and communities and this is especially evident when working with Aboriginal communities profoundly impacted by the individual and collective experiences and layers of trauma from historical events associated with the colonisation of Indigenous land and genocide. Atkinson et al. (2010) describes a process of 'intergenerational trauma', that is, the passing of trauma legacies through generations to children, tracing distinctive 'trauma lines' from first contact through to contemporary experiences of marginalisation and dispossession. This trauma can be exacerbated by current injustices Aboriginal people face in using or working in mainstream health services. Work with these communities must include culturally safe and culturally competent health services, culturally informed ways of working, and self-determination.

Despite the abuses experienced, Aboriginal people and communities remain resilient and deeply connected to their culture, kinship, family and history (NSW Ministry of Health, 2012; Zubrick et al., 2010). For Aboriginal people, 'culture is about family networks, Elders and ancestors. It's about relationships, languages, dance, ceremony and heritage. Culture is about spiritual connection to our lands and waters. It is the way we pass on stories and knowledge to our babies and children; it is how we greet each other and look for connection. It is about all the parts that bind us together.' (Jackomos, 2015). It is also evident that building connection to culture and community can help buffer children, young people and families in the face of adversity, including violence, abuse and neglect (Bamblett, Frederico, Harrison, Jackson, & Lewis, 2012).

Cultural respect and practice must therefore include a holistic consideration of the emotional, mental, physical, relational and spiritual wellbeing of people across the life span. Equally great significance is given to relationships, which extend beyond the immediate family and are inclusive of connection to kinship systems, the wider community, the land, and spirituality. In this regard Caruana (2011) notes that the 'protective attributes — some of which (such as continuing strength of kinship systems, and the maintenance of connection to spiritual traditions, ancestry, country and community) can be seen as being unique to transcend painful personal histories'.



This is consistent with what the Royal Commission (2017) identified as the importance of Aboriginal and Torres Strait Islander healing approaches that emphasise connecting to culture and affirming a positive Aboriginal identity, including restoring family and community relationships. The Royal Commission drew attention to evidence supporting how connection to culture supports resilience and that a collective focus within these healing approaches can assist in intergenerational healing. Responses to Aboriginal people therefore require consideration not only of the importance of extended family and community relationships but also collaboration with Aboriginal communities, including agencies providing Aboriginal healing programs.

NSW Health staff will apply the [Cultural Respect Framework 2016-2026 for Aboriginal and Torres Strait Islander Health](#) (Australian Health Ministers' Advisory Council National Aboriginal and Torres Strait Islander Health Standing Committee, 2016). It identifies that embedding cultural respect through cultural safety and responsiveness into the design, delivery and evaluation of health services supports:

- improved health outcomes and equality
- more timely, efficient and effective services
- financial benefits and efficiencies
- a diversely skilled and dynamic workforce
- a reduction in experiences of racism and discrimination
- improved consumer and community satisfaction.

To embed cultural safety and responsiveness into the design, delivery and evaluation of SASs, to begin to address injustices that Aboriginal people and communities have experienced, and to provide support to Aboriginal people, communities and workers in responding to sexual assault, the following four key areas need to be actioned:

1. cultural safety and cultural competence
2. community engagement
3. Aboriginal cultural consultation
4. supporting the Aboriginal workforce.

These four elements are outlined in greater detail below. Each SAS will develop an Aboriginal Action Plan (see template at [Appendix 9](#), which may be adapted to suit local needs) to document how it will work towards addressing these four key areas. This will be developed in collaboration with Aboriginal Health staff within and outside the SAS as appropriate, and with local Aboriginal communities, organisations and services, such as Aboriginal Community Controlled Health Organisations (ACCHOs). This is to be completed as a part of normal service planning ([Section 23.4](#)) and done at a minimum annually, or more frequently if required.

## **21.2 Cultural safety and cultural competence**

The development of culturally safe and culturally competent health services is a key strategic direction of the [NSW Aboriginal Health Plan 2013-2023](#). Cultural safety involves Aboriginal people and families feeling and believing that their Aboriginal identity is valued and respected, and being provided the freedom to express their identity (VACCA, 2008). This enables individuals and communities to experience a culturally safe atmosphere in a health service where they are not judged, misunderstood or assaulted on the basis of their cultural identity and connection.

Cultural safety is conceptualised along a continuum from cultural destructiveness to cultural proficiency (Cross et al., 1989). Individuals and organisations can work towards culturally safe practice as a journey. It is not a destination that once achieved is complete. This journey involves attitudes, policies, and practices.

Cultural safety involves Aboriginal people and communities feeling and believing their Aboriginal identity is valued and respected, and are allowed freedom to express their identity (VACCA, 2008). Culturally safe practice can only increase the accessibility and safety of mainstream health services for Aboriginal people if it acknowledges and aims to address the trauma and ongoing racism Aboriginal people continue to experience (Herring, Spangaro, Lauw, & McNamara, 2013).

SASs will take steps towards this by ensuring Aboriginal people and communities are treated with respect and courtesy in every interaction, and that SAS premises are welcoming and inclusive. This includes, but is by no means limited to:

- The placing of items of cultural relevance, including maps, pictures and paintings, which are sourced in consultation with local Aboriginal communities and/or the local Aboriginal Land Council, and in line with existing NSW Health policies.
- Where possible, displaying information and posters and have service pamphlets written in culturally appropriate language and style specifically for Aboriginal people, families and communities.
- In interventions, SAS staff will have knowledge of and respect for Aboriginal worldviews, and engagement will be sensitive, empowering and respectful, and support self-determination wherever possible. This includes, for example, consideration of the gender of the staff member particularly in the context of medical and forensic examinations.
- Where appropriate, available, and safe to do so, services are provided in flexible locations preferred by the Aboriginal people, including outreach and outdoor spaces, and there is flexibility regarding meeting times and the duration of appointments.
- SAS staff will meet with clients in a location where their privacy and confidentiality can best be maintained, acknowledging this is especially, although not exclusively, more difficult in some rural and remote areas. It is important to note community dynamics are unique to each individual community, and some Aboriginal clients may or may not see Aboriginal Services (e.g. ACCHOS or Aboriginal Medical Service [AMS]) or even Community Health Centres or SASs as spaces where their privacy and confidentiality can be maintained.
- Throughout work with an Aboriginal client, SAS staff are to engage in cultural consultation ([Section 21.4](#)) to ensure cultural safety. Where possible and welcomed by the client, SASs will co-work and/or undertake joint visits with Aboriginal workers or organisations.

- Ensuring that key elements of the SAS role, for example advocacy and systems advocacy, include challenging racial prejudice and supporting culturally appropriate and safe responses within systems such as the legal system.

Ensuring cultural safety involves recognising the importance of the traditional and ongoing roles and knowledge of Aboriginal men and women, kinship structures, connection to family, community and country, and the importance of this to Aboriginal people. This entails understanding the different roles and needs of adults and children, of men and women, and of boys and girls while also recognising that Aboriginal men and Aboriginal women survivors of sexual assault, like all survivors, require an individual approach to therapeutic healing based on needs. Cultural consultation is critical to avoid misunderstandings or false assumptions. This includes understanding that sexual assault is not part of Aboriginal culture and as such may be community business rather than men's business or women's business. It is important to note here community dynamics are unique and each community may have different common beliefs around sexual assault and men's and women's business as being separate.

As outlined in Herring et al. (2013), cultural competence can only be effective in increasing the accessibility and safety of mainstream health services for Aboriginal people if it addresses the trauma and ongoing racism that Aboriginal people experience. Herring et al. (2013) cite the definition of cultural competence as

a system of care that acknowledges and incorporates the importance of culture, the assessment of cross-cultural relations, vigilance towards the dynamics that result from cross-cultural differences, the expansion of cultural knowledge, and the adaptation of services to meet culturally unique needs. (Cross, Bazron, Dennis & Isaacs, 1989 in Herring et al., 2013, p. 3)

Herring et al. (2013) provide a framework for working towards trauma and racism-informed cultural competence, whereby practitioners and organisations can take the 'careful and patient' steps of becoming informed, taking a stance and reaching out to their local Aboriginal communities. This framework is summarised in Figure 14.

Working towards cultural competence is a responsibility of all SAS staff. Trauma and racism-informed cultural competence involves a series of steps to be taken primarily by non-Aboriginal staff. SAS managers and clinical leads are crucial in leading this process within the team and in facilitating and engaging in ongoing reflection and review on cultural competence in clinical supervision, cultural supervision, planning meetings, training and in daily practice ([Section 23.6.6](#)). In addition to training (identified at the beginning of this section), each SAS counsellor, manager and clinical lead should also engage in regular, individual and group cultural supervision, cultural consultation ([Section 21.4](#)) and continual development and fostering of effective and long-term sustainable working relationships with Aboriginal organisations and reputable community members.

**Figure 14: Working towards trauma and racism-informed cultural competence**

Adapted from Herring et al. (2013)

	Personal steps	Practice steps	Organisational steps
<b>Becoming informed</b>	Awareness of the full history of Aboriginal people, of living cultural practices, of ongoing racism and persecution.	Researching barriers to using mainstream services faced by Aboriginal people (including isolation as a result of racism and intimidation), learning about local Aboriginal communities, history, practices, organisations and spokespeople.	Ensure staff are sufficiently trained in issues, such as Aboriginal history, culture, contemporary and social determinants, and trauma legacies, conduct and document scoping to establish the profile and service use by Aboriginal clients against the local population, identify existing policies for recruitment and support of Aboriginal staff, identify existing Aboriginal voices in the organisation.
<b>Taking a stance</b>	Recognition of the benefits of white privilege, willingness to name and confront racism against Aboriginal people.	Recognition that the service is discriminating against the Aboriginal community unless the client base reflects the Aboriginal population and the proportion of those experiencing a given problem that are Aboriginal.	Develop a draft plan for how training, policy revision and consultation will occur, prioritise access by Aboriginal people to the service in terms of time, resources and ongoing commitment.
<b>Reaching out</b>	Reading the work of Aboriginal writers, supporting Aboriginal cultural events, taking the initiative to engage with Aboriginal colleagues and acquaintances	Reach out to local cultural brokers, introduce themselves, spend time and identify ways to consult with and support the local community.	Contact local cultural brokers, spend time building relationships and trust, identify and offer resources (e.g. venue spaces for meetings, provision of training, provision of volunteers for celebration days), listen and ask what is needed, involve Aboriginal staff in decision-making, mentoring and supervision.

### **21.2.1 Cultural safety in therapeutic interventions**

Each SAS team and worker needs to listen, reflect and consider whether their practice demonstrates understanding and respect of Aboriginal history, and Aboriginal culture and community today. A key step is to form a proactive and collaborative working relationship with Aboriginal workers and organisations.

Wherever possible, SASs will provide Aboriginal clients with a choice of whether or not their individual counsellor or worker is an Aboriginal or non-Aboriginal person. Efforts are also to be made to ensure that Aboriginal children/young people have access to an Aboriginal SAS counsellor of their preferred gender in the context of cultural standards and expectations relating to sexuality and development.

If there is no Aboriginal SAS worker, the client will be offered an Aboriginal worker or support person to participate in the sessions. This would require co-working with Aboriginal counsellors or other health workers outside the SAS, including Aboriginal organisations (e.g. ACCHOS and AMSs), especially at key decision-making points.

In considering how to undertake assessment, planning and work with Aboriginal clients, SAS counsellors need to ensure their approach has a foundation of cultural respect and knowledge. It also requires considering the impact of trans-generational trauma on the client, extended family and community. This may include a family member being one of the Stolen Generations, the removal of children, high rates of suicide, systematic and direct racism, oppression, acculturation and widespread grief and loss. Aboriginal communities have experienced widespread trauma and disadvantage in a systemic and community-wide basis as a part of government policy. It requires vigilance and a concerted effort from the service system, including SAS counsellors, to not repeat policy and practice mistakes of the past. Other consideration for SAS counsellors include:

- understanding the impact of broken connections to culture and community and that repairing these connections are essential to recovery from abuse
- understanding that the historical context and legacy of collective and intergenerational trauma is essential to understanding the experiences of, impacts on and support needs of Aboriginal victims and survivors of abuse
- providing outreach ([Section 13.2.2](#)) to Aboriginal clients in environments they feel safe, which may include their home or Aboriginal organisations
- Western models of therapeutic support and recovery may be inappropriate, insufficient or even harmful for many Aboriginal survivors and culturally informed ways of healing are required. Culturally safe spaces need to be combined with mixed therapeutic approaches, including Aboriginal Healing framework principles and culturally holistic healing approaches, alongside Western approaches.
- Aboriginal approaches to healing emphasise family and human relatedness, and individual wellbeing is intimately associated with collective wellbeing. It is therefore particularly important to engage with Aboriginal staff around referrals, intake, assessments, clinical discussions, case reviews and ways of working with families, including cultural values and practices to consider in addition to how to engage with Aboriginal communities.



## 21.3 Community engagement

Engagement with local Aboriginal communities is a core part of SAS work and is essential in achieving positive outcomes for the clients and communities. Community engagement involves earning and gaining a community's trust and respect, and working towards collaboration with the community around the safety and wellbeing of the community and members. Without this trust and respect, SASs may find that any attempt at providing a service to local Aboriginal communities will not be effective.

Community engagement or **reaching out**, should only be undertaken when an organisation and its staff have carefully taken the steps of **becoming informed** and **taking a stance** (Herring et al., 2013). Community engagement involves creating, developing and sustaining relationships with Aboriginal people and communities based on trust, safety, respect and transparency.

Community engagement for SASs may look different for each service due to their diverse geographical, social, and cultural contexts. Each SAS will also have its own style of management and composition of staff and practitioners, which will have a bearing on the way community engagement happens in that area. This ideally includes specific Aboriginal community development workers. Community engagement will be a deliberate and planned activity of SASs and will be documented in the Aboriginal Action Plan. SASs are also to pay particular attention to engagement with men, include them in service delivery, and understand the role that men played before colonisation, and how intergenerational trauma has affected this and their trauma as well. Planning, activity and outcomes connected to the core purpose of SASs are to be recorded and reported on together with reports of direct clinical services.

The SASs are also part of the broader violence prevention and response provided by districts/networks, and, as such, will contribute to the community engagement process undertaken in their local area. In accordance with this overall response, a SAS will proactively and respectfully engage with Aboriginal communities in developing effective service responses. The SASs will need to work in concert with the overall district/network strategy so as not to increase the burden of Aboriginal organisations in terms of attendance at meetings and processes. Community engagement can include:

- sharing information in accessible language and formats with Aboriginal clients and communities about SASs and other mainstream services, including what their rights are and how to navigate service systems as well as providing advocacy in this context
- as part of an interagency response, supporting clients and communities to manage the impacts of intergenerational trauma and oppression, e.g. Stolen Generations, removal of Aboriginal children/young people
- working with Aboriginal communities to consider key training and other messages from relevant community organisations regarding current and intergenerational trauma and oppression, e.g. impact of Stolen Generations, removal of Aboriginal children/young people and colonisation
- developing strong links with [ECAV](#) local Strong Aboriginal Men (SAM), Strong Aboriginal Women (SAW), and Weaving the Net (WTN) programs
- linking clients with local Aboriginal community or Aboriginal organisations, especially when they are not already connected to culture and community and sharing information with these services for better referral pathways and access



- working alongside SAS Aboriginal staff or Aboriginal organisations to create, identify and prioritise cultural needs in communities.

Consequences of not prioritising community engagement can include potential damage to relationships between SASs and local communities, lack of awareness about local communities, and isolation of other workers in small communities relying on SAS counsellors for support.

Community engagement is a whole-of-service responsibility carried by all SAS counsellors. All staff are accountable for their participation and commitment to these activities with Aboriginal clients and their communities. SAS managers and clinical leads play a key role in supporting SAS counsellors to effectively reach out to Aboriginal communities, and ensure that time and resources are made available for this purpose. SAS managers and clinical leads will facilitate discussions with the team to explore and document issues such as:

- roles and responsibilities of the SAS staff, and what is understood about these
- identifying and prioritising specific communities and identifying existing contacts within the communities or people that can facilitate contact
- learning about the strengths and needs of the communities
- seeking the views of communities and various community members
- identifying risks/barriers that might exist and how to address these
- identifying issues, and making and implementing a plan to address these (e.g. identifying activities needed and the frequency of these, as well as what reciprocal relationships are possible where each contributes in some way to the other, such as with Aboriginal organisations)
- seeking feedback from the communities about outcomes.

When engaging with local Aboriginal communities, SAS counsellors must be respectful of cultural protocols and practices. Consideration is given to dress code and the appropriate use of language and body language, and workers are mindful of competing demands on the time of Aboriginal people who are involved in organising the engagement activities in their communities. Respect is shown to Elders and other leaders in the communities. Care and respect is shown when a community has Sorry Business, by following local protocols and providing respectful space to the community. As stated by Herring et al. (2013), reaching out can begin by providing offers of support and resources, rather than awaiting requests from the Aboriginal communities.

## **21.4 Seeking Aboriginal cultural consultation**

Aboriginal cultural consultation is a process where a non-Aboriginal worker seeks the advice and guidance of an Aboriginal worker in their work with an Aboriginal client. It may also involve the Aboriginal worker consulting directly with the client regarding their culture or identity. If there are Aboriginal workers in the SAS, they may be in a position to co-work or provide direct consultation with the person and their family or community. Alternatively, a worker from outside the district/network, for example from an ACCHO, may be able to provide this consultation.

Consultation is an important way of valuing, respecting and learning from the cultural expertise of Aboriginal people, and of supporting Aboriginal clients to connect to or remain connected to their culture. Prioritising and respecting Aboriginal cultural consultation recognises that there are

Aboriginal worldviews that differ greatly from non-Aboriginal perspectives. It also recognises that many traditional customary laws continue to exist and remain strong in Aboriginal families and communities. It is essential that non-Aboriginal workers consult with Aboriginal workers about these issues to make informed decisions and practice in an ethical way.

Cultural consultation is aimed at supporting clients and their families/communities to maintain or develop cultural connection to family, community and country to assist social and emotional wellbeing. Family and connections may be a healing agent on their own and, where possible, this must be acknowledged. The significance of Aboriginal Elders in a client's life must be recognised and it may be appropriate to involve an Elder/s in the healing process. However, the privacy and confidentiality of the client within their community must be always be taken into consideration. Aboriginal people have been nurturing each other for thousands of years, and Aboriginal family systems provide many of the ingredients of the Western view of the therapeutic relationship, e.g. hope, integrity, relationship, trust and rhythm. Connection to culture is a part of an Aboriginal client's identity and understanding of where they are from and their situation in the world.

The first and routine part of consultation occurs within the SAS from the time of referral. At every referral, cultural consultation is to be considered to ensure best practice and cultural safety for all Aboriginal children, young people and their families. The advice is generally sought and recorded at team intake and clinical meetings (e.g. case review) and placed on the client's record, but advice may be sought at any time assistance is required. A *Template to record Aboriginal cultural consultation* is at [Appendix 9](#) to support recording this advice. However, this may be adapted to suit local needs. If completed, this form is to be included in the client record.

A direct Aboriginal cultural consultation is to be undertaken for all clients engaged in the service where they consent to this taking place. SASs will develop local procedures for Aboriginal consultation in collaboration with relevant Aboriginal Health staff and local Aboriginal services. The process of development and review of procedures can be included in the Aboriginal Action Plan. These procedures will reflect the Aboriginal staff available to the SAS, including in the broader district/network or outside the organisation, and the needs of local Aboriginal communities. The following guidelines can be useful in developing these procedures and in assisting a non-Aboriginal SAS counsellor to ensure that appropriate cultural consultation occurs:

- Inform the client of the practice of cultural consultation at their first meeting with the SAS, and explore and record their wishes in relation to this, and develop a plan during the assessment phase for meeting these wishes.
- In some circumstances, cultural consultation may be provided by an Aboriginal worker from outside the service. This may be arranged when the Aboriginal worker is unavailable, there is no Aboriginal worker, or another worker is more relevant to the client's needs at the time.
- During the cultural consultation process, the confidentiality of Aboriginal staff is to be maintained, as in some circumstances their identity being known could place the Aboriginal staff member at risk of harm, particularly if the matter is before a court, a JCPRP matter or a child protection matter where children have been removed.
- Aboriginal Consultation is best undertaken with the guidance of either an Aboriginal Health Manager or where possible district Aboriginal Wellbeing and Violence Prevention Coordinators, to ensure the cultural safety of the Aboriginal staff being consulted with. This is especially due to the content of why this consult is occurring. This guidance will include

who can be asked to be an Aboriginal consultant and considerations about the confidentiality and safety for the Aboriginal consultant needs to be addressed.

- Cultural consultation takes place at key points during the client's journey, e.g. assessment phase, or change in circumstance (e.g. carer, significant event, death/Sorry Business). At a minimum, consultation is to take place during the review period every four months. An *Aboriginal consultation cover sheet* (see template at [Appendix 10](#), though this may be adapted to suit local needs) is placed at or near the front of the client's file to provide an accessible overview of cultural consultations for the client and their family/carers.
- Consultation will take place when therapeutic interventions or other aspects of the work are not progressing well, or there is deterioration or increased risk in the client's situation.
- In most instances, consultation meetings occur face to face or, alternatively and after negotiation, via telephone, teleconference or videoconference. Consultations are scheduled and planned, and a brief summary of the client's history is provided to the Aboriginal worker prior to the consultation to allow them the opportunity to declare a conflict of interest.
- Where an Aboriginal worker identifies a conflict of interest, the SAS counsellor and clinical lead are to support the worker and the client to come to a collective decision on how this will be managed. Collaboration is required with Aboriginal workers from other organisations.
- Each consultation is documented by negotiation with all parties using the *Template to record Aboriginal cultural consultation* ([Appendix 9](#)) or an adapted or equivalent local form, signed by all parties and filed in the client's file.

Non-Aboriginal SAS counsellors workers will consult closely with Aboriginal SAS counsellors or other Aboriginal health workers when working with Aboriginal clients and their families to ensure cultural safety. Where possible, and where the client consents, all families where there is a family member or members who identify as Aboriginal will be able to speak with an Aboriginal worker to discuss Aboriginal cultural issues, even though the primary therapeutic engagement may be with a non-Aboriginal worker. Where appropriate, feedback will be provided by the Aboriginal worker to the non-Aboriginal worker/s working with the family. Consultation may take place around issues such as verbal and non-verbal communication, cultural protocols, potential barriers to progression in therapy (which may be to do with service provision, cultural issues or other issues), and planning of client pathways and sessions.

SAS managers and clinical leads are responsible for overseeing the practice of Aboriginal consultation within the team, and will have systems in place to ensure non-Aboriginal SAS counsellors' engagement in Aboriginal consultation, and to support Aboriginal counsellors in their work around cultural consultation.

## **21.5 Aboriginal workforce**

The success of developing and supporting the SAS Aboriginal workforce will have a strong relationship with the strength and quality of the work achieved in the other three areas of work identified in the Aboriginal Action Plans.

NSW Health acknowledges the value and importance of employing Aboriginal practitioners within Health services to NSW Health as an organisation, and to the health of the Aboriginal people and communities of NSW. It recognises the impact of colonisation, racism, oppression, persecution and trauma on Aboriginal workers, and the dynamics of power and privilege in the workplace, and

supports Aboriginal practitioners to navigate this journey. NSW Health highly values the cultural expertise, skills, knowledge and abilities of Aboriginal practitioners and is committed to increasing the Aboriginal workforce, with an aspirational target of 1.8 per cent Aboriginal representation at all salary levels and occupations across all organisations to be achieved by 2023. SASs will consider local population data and need as they develop this aspect of their Aboriginal Action Plan. Involving local Aboriginal communities and organisations in the planning and decision-making process is essential to the success of the development and support of the Aboriginal workforce.

Developing, supporting and learning from an Aboriginal SAS and other Health workforce, with due consideration to their cultural safety and challenges and opportunities of living and working in community, is vital for effective work with Aboriginal people and communities. This includes supporting Aboriginal workers to access cultural leadership and considering the complexities Aboriginal staff face with systemic racism and white privilege. It also means supporting their role as cultural knowledge keepers and providing opportunities to upskill and build on knowledge.

SASs must be active in promoting an Aboriginal SAS workforce and addressing equity in pay gaps and career progression. In addition to recruiting qualified Aboriginal workers into current positions (23.6.3), each SAS will recruit to at least one identified Aboriginal position for a worker completing the [ECAV](#) Aboriginal Qualification Pathway. Once the worker is qualified, SAS management are responsible for ensuring the worker receives appropriate pay and position. Another Aboriginal worker can then be recruited into the vacated position while they complete the Pathway. The Aboriginal Action Plan will document how this will be achieved in the context of a strategic approach to the Aboriginal workforce in the SAS. The Aboriginal Action Plan will also include support structures for Aboriginal workers.

The SASs will provide cultural supervision for all staff and development and training for Aboriginal practitioners. Current options/arrangements for cultural supervisors include through: NSW Health; ECAV; and/or external cultural supervisors. Frequency of cultural supervision is to be determined based on local needs, but as a guide may include: whole-of-team cultural supervision quarterly, managers every two months, and Aboriginal practitioners monthly. SAS will also support Aboriginal counsellors to attend relevant Aboriginal counsellors network meetings.

The [Aboriginal Workforce Unit](#) is part of the Workforce Planning and Development Branch, NSW Ministry of Health, whose core business includes increasing the Aboriginal health workforce and developing policies and strategies to support this workforce growth. They have developed [Stepping Up](#), an online recruitment resource for Aboriginal applicants and hiring managers.

## PART FOUR: SEXUAL ASSAULT SERVICES MANAGEMENT

### 22 INFORMATION SHARING AND CLIENT RECORDS

#### 22 Information sharing and client records: summary

- SASs will maintain comprehensive records in accordance with [Health Care Records — Documentation and Management](#) to enable effective therapeutic case planning, management and evaluation and improved client outcomes.
- There is to be evidence on the client's record of informed consent, including the limitations of confidentiality.
- SASs will ensure systems are in place to maintain confidentiality and protect the privacy of people in accordance with privacy legislation and NSW Health policies, specifically the [Privacy Manual for Health Information](#) and the [Privacy Management Plan](#).
- SASs will retain hard copy and electronic copies of client records (including the MFER) according to the NSW Government's policy on [Health Services, Public: Patient/Client records](#)
- SASs will share information as guided by the [Privacy Manual for Health Information](#) including under Part 16A of the [Children and Young Persons Care and Protection Act 1998](#) and Part 13A of the [Crimes \(Domestic and Personal Violence\) Act 2007](#).
- SASs will have in place processes for information sharing and access to records.

The way client information is gathered, recorded, stored and shared is fundamental to professional clinical practice. From referral through to assessment, case formulation, case planning, therapeutic intervention and closure, information is gathered and interpreted to gain insight into the person's experience, and to guide the process. Information about a person belongs to that person. A quality clinical service only has access to such information on the understanding it is gathered purposefully, accuracy is safeguarded, and information is treated with respect and shared with others when needed to enhance the safety and wellbeing of the individual. Subject to the relevant legislative and policy requirements, the client's best interests will inform how records are kept and how and when information is shared.

#### 22.1 Client records

SAS will maintain accurate and comprehensive records to enable effective therapeutic case planning, management and evaluation, and improved client outcomes. In doing so, SASs are required to comply with the NSW Health Policy Directive on [Health Care Records — Documentation and Management](#), which is the primary reference point regarding client records. Below is a summary of the key requirements of that policy directive concerning client records as they relate to a SAS context. It provides general information about SAS records and is best also read in conjunction with [Section 15.14](#), which provides information specific to records about medical and forensic interventions.



Client records are used to promote client safety, continuity of service, and support the transfer of information when a case is transferred from one worker or team to another. Client records provide an important role in review, such as when a client's situation is deteriorating or other difficulties arise. SASs will maintain a register of all clients who present to the service and keep records for every subsequent client contact.

### **22.1.1 Hard copy files**

Where hard copy files are used in SASs, these will be securely stored and retained in accordance with NSW Health and district/network policies and procedures as well as legislative requirements.

### **22.1.2 Electronic clinical record systems**

Where SASs use an electronic record system, SASs will:

- ensure access is limited in accordance with security and confidentiality requirements ([Section 22.1.4](#)).
- complete electronic forms for every new client and all subsequent client contact, guided by relevant statewide and local policy and procedures for clinical systems and data collection
- monitor direct service provision using the data collected
- keep information about all services provided
- make de-identified information available to the district/network for planning and reporting purposes
- give access to de-identified data to the Ministry of Health for planning and reporting.

The MFER may be scanned and kept electronically, however the original document are only to be destroyed where the circumstances comply with the [General Disposal Authority 45](#), which sets out when an electronic copy can be retained instead of the hardcopy.

### **22.1.3 Content of client psychosocial records**

The following outlines requirements for client records for psychosocial interventions, while Section 15.14 outlines the requirements for records for medical or medical and forensic interventions.

SASs will maintain comprehensive client records of each client's episodes of service that are contemporaneous. A client record must be created and available for every client. SAS counsellors will take care with what and how they record their interventions with clients, with particular attention to accuracy, and noting that, notwithstanding the Sexual Assault Communications Privilege ([Section 22.2.6](#)), client records may still be subpoenaed. SAS counsellors will clearly differentiate facts and statements from professional opinion and intervention planning. It is also good practice to contextualise client statements with information about common reactions to sexual assault.

Where interventions involve multiple family members, each family member requires their own registration and eMR, and information pertaining to a particular family member is not to be detailed in another family member's eMR except where directly clinically relevant.

The psychosocial client record will include a range of information gathered over time. At a minimum this will include documentation, where relevant, of:



- referral and intake (Sections [13.1](#) and [13.3](#))
- evidence on the client record about informed consent for psychosocial interventions ([Section 13.4](#))
- initial assessment ([Section 13.5.2](#))
- crisis response ([Section 14](#))
- comprehensive assessment ([Section 16.2](#))
- ongoing case plan ([Section 16.3](#))
- record of contact with other agencies and workers (e.g. DCJ, JCPRP, schools, and other health professionals)
- case notes
- other assessments, reviews and closure reports (Sections [16.7](#) & [16.8](#))
- copies of letters or emails sent and received.

#### **22.1.4 Security and confidentiality of records**

SASs will ensure systems are in place for the confidentiality of client files in accordance with NSW Health policy directives including, but not limited to, the [Privacy Manual for Health Information](#) and the [Privacy Management Plan](#). Nevertheless, a SAS's record management system needs to provide confidentiality for the client, while at the same time ensuring that, when necessary, files can be located by the NSW Health system and that pertinent issues for the client and opportunities for service collaboration can be identified.

SAS clients and their family/significant others will be made aware of policy and legal obligations that may impact on client confidentiality and the circumstances in which health information may be disclosed, including:

- to protect the person's safety
- child protection and police reporting requirements ([Section 4](#))
- subpoenas of notes and medical records ([Section 22.2.5](#)).

Children and young people have the right to privacy with their health information and to make their own decisions regarding their privacy where they are competent to do so.

Information regarding a sexual assault is extremely sensitive material and will not be contained in a general health record. The NSW Health [Privacy Manual for Health Information](#) notes certain differences for SAS records compared to other health records with respect to restricting access to records. These include a requirement that:

- SAS client records be maintained separately from the general health record.
- SAS records can only be linked to the general health record via a notation that a 'confidential health record exists'.
- Access to SAS client records for care and treatment purposes is restricted and can only be made via a designated contact within the SAS (usually the SAS manager or clinical lead), who will seek the client's consent first.

Other access to SAS records may include:

- a client to whom the record relates, or their authorised agent, based on a case by case basis in accordance with health service release of information policies and privacy laws
- other personnel/organisations/individuals in accordance with a court subpoena, statutory authority, valid search warrant, coronial summons, or other lawful order authorised by legislation or NSW Health policy (Sections [22.2.5](#) & [22.2.6](#)).

SASs will ensure that:

- All SAS records are kept secure at all times.
- Access to SAS records will only be allowed after careful consideration by the SAS and discussion with the client, if appropriate and where possible.
- There are local procedures to ensure that the names of victims cannot be accessed via any manual/computerised client registrations of the community health centre/hospital without the approval of SAS.
- Any computer systems installed reflect the limited access identified above.
- Every facility ensures security of storage, including archived storage.

#### **22.1.5 Record retention**

SASs will retain hard copy and electronic copies of client records (including the MFER) according to the NSW Government's policy on [Health Services, Public: Patient/Client records](#), which requires:

- for adult victims, records are to be retained for a minimum of 30 years after date of last contact with the service, or request for access or legal event, or
- for victims who are minors, records are to be retained for 45 years after the date of last contact with the services, or request for access or legal event.

In relation to the MFER (see also SAIKs at [Section 15.12](#)), it is important to note that forensic science continues to develop and cold cases may be taken to court more than 20 years after the offence occurred as DNA or other evidence becomes available.

Most hard copy originals are authorised for destruction after imaging (making into electronic records), provided a number of conditions are met. Guidance is provided on these conditions in the [General retention and disposal authority: original or source records that have been copied](#).

## **22.2 Information sharing and privacy**

### **22.2.1 Privacy and limited confidentiality**

Clients accept services from SASs on the understanding that, within statutory limitations, they are attending a confidential service. Clients have a right to know that records are secure and that they will be securely stored beyond their presentation to the service.

All NSW Health services must collect, use and disclose health and personal information in accordance with NSW privacy legislation, particularly the [Health Records and Information Privacy Act 2002](#) (HRIPA).

A lawful excuse to disclose health information would include information disclosed to a court under a subpoena, in accordance with reporting requirement described in [Section 4](#), and under Chapter 16A of the [Children and Young Persons Care and Protection Act 1998](#) and Part 13A of the [Crimes \(Domestic and Personal Violence\) Act 2007](#).

SAS staff will inform clients about privacy and limited confidentiality, namely that their information may be shared with third parties (such as DCJ, NSW Police and other agencies) where necessary and particularly in the interests of safety and wellbeing in accordance with law and policy ([Section 4](#)). Information about limited confidentiality will be provided at the first point of contact, and revisited during the assessment and other interventions as appropriate. Where a new or additional family member/significant other becomes involved, SAS counsellors will inform them of limited confidentiality.

### **22.2.2 Information-sharing under Chapter 16A of the Care Act**

In addition to the provisions in Section 27, Chapter 16A of the [CYPCP Act](#) creates a legal mechanism for the sharing of information when requested by a prescribed body. Information shared in accordance with Chapter 16A is a lawful excuse for the purposes of [HRIP Act](#) (as discussed above). A prescribed body as defined in the [CYPCP Act](#) includes any of the following:

- the NSW Police Force, a Public Service agency or a public authority
- a government school or a registered non-government school within the meaning of the *Education Act 1990*
- a TAFE establishment within the meaning of the *Technical and Further Education Commission Act 1990*
- a public health organisation within the meaning of the *Health Services Act 1997*
- a private health facility within the meaning of the *Private Health Facilities Act 2007*
- any other body or class of bodies (including an unincorporated body or bodies) prescribed by the [CYPCP Act](#) for the purposes of this section, which includes: enrolled nurses and registered nurses; medical practitioners; midwives; psychologists; occupational therapists; and speech pathologists eligible for membership of Speech Pathology Australia.

Chapter 16A enables SASs to provide information relating to the safety, welfare or wellbeing of a particular child or young person or class of children or young people to another prescribed body if SAS staff reasonably believe that the provision of the information would assist the recipient to:

- make any decision, assessment or plan or to initiate or conduct any investigation, or to provide any service relating to the safety, welfare or wellbeing of the child or young person or class of children or young people, or
- manage any risk to the child or young person (or class of children or young persons) that might arise in the recipient's capacity as an employer or designated agency. This includes providing sufficient information to meet that employer's obligations under the NSW [Ombudsman Act 1974](#).

In general, SAS counsellors are not to exchange information relating to sexual assault counselling communications under Chapter 16A except in cases where a child or young person (or class of children or young people) may be at risk of significant harm if the information was not exchanged, or where the victim has consented.

If a request is made under Chapter 16A captures records that are sexual assault counselling communications for adults, SAS workers will discuss the request with the prescribed body to determine if the records are necessary, and if so what action can be taken to ensure they are not disclosed further. See section 22.2.6 for more information.

While consent for information sharing is not necessary in these circumstances, it will be sought where possible. Organisations should at a minimum advise children, young people and their families that information may be shared with other organisations. The local district/network privacy contact officer can be contacted for advice.

NSW Health workers will consult with DCJ and/or NSW Police if appropriate in the circumstances to help determine when and how to share relevant information under Section 16A to ensure that doing so will not interfere with an active investigation.

Further information about information-sharing under this Act is available at [Child Wellbeing and Child Protection Policies and Procedures for NSW Health](#).

### **22.2.3 Information-sharing under Chapter 13A of the *Crimes (Domestic and Personal Violence) Act 2007***

Part 13A of the [Crimes \(Domestic and Personal Violence\) Act 2007](#) allows the sharing of information in certain circumstances related to domestic violence and has effect despite any provision under the NSW privacy legislation.

In particular, in the case of a serious domestic violence threat<sup>42</sup> an agency<sup>43</sup> may, despite the privacy legislation, deal with (collect, use or disclosure) information about a person without the consent of the person:

- If the agency believes on reasonable grounds that:
  - a) the particular dealing is necessary to prevent or lessen a domestic violence threat to the person or any other person, and
  - b) the threat is a serious threat, and
  - c) the person has refused to give consent or it is unreasonable or impractical to obtain the person's consent.
- Where 'there is a valid threat assessment evidencing the victim is at serious threat'<sup>44</sup>

<sup>42</sup> Where 'threat' is defined in the Act as a threat to the life, health or safety of a person that occurs because of the commission or possible commission of a domestic violence offence (where the types of offences and relationship between parties are specified further in the Act).

<sup>43</sup> Defined in the Act as a public sector agency within the meaning of the *Privacy and Personal Information Protection Act 1998*, or an organisation within the meaning of the *Health Records and Information Privacy Act 2002* to which that Act applies.

<sup>44</sup> Refer to Section 13 of the NSW Government Domestic Violence Information Sharing Protocol for further information

Where there are concerns about the safety, welfare or wellbeing of children, Chapter 16A of the [CYPCP Act](#) applies, enabling information to be shared without consent to coordinate services and support to children and their families. This includes the sharing of information about unborn children, where a report to the Child Protection Helpline or CWU has been made. Planning for the safety, welfare and wellbeing of children and reported unborn babies is paramount when responding to all forms of domestic and family violence.

If however, NSW Health staff assess that the domestic and family violence threat is not a serious threat and no children are involved, then consent is always required to share information under Part 13A. Note that in order to share information under Part 13A, it must initially be shared with either the Central Referral Point or Local Coordination Point prior to being shared with other domestic violence support services<sup>45</sup>. Note importantly that disclosure of information under Part 13A requires the consent of the victim, and not the consent of the threatening person.

To share information under Part 13A, services must comply with the provisions and standards contained within the [Domestic Violence Information-sharing Protocol](#) under the NSW Government's [Safer Pathway](#). NSW Health staff will refer to the Protocol and consult the staff who coordinate the Local Health Districts' participation in the local Safety Action Meetings to guide their decision-making. The NSW Health [Use of Exchange of Information Part 13A Crimes \(Domestic and Family Violence\) Act 2007 Form and Information Bulletin \(IB2016\\_056\)](#) has been developed to assist NSW Health workers comply with requirements under the legislation.

Other resources that may also be of value in guiding NSW Health staff in their decision-making around these issues are available on the [Safer Pathway](#) website and include the [Information-sharing process flowchart](#), [Information-sharing consent flowchart](#), and a [Fact sheet for victims](#).

#### **22.2.4 Process for information-sharing and access to files**

Caution is to be applied to verify the identity of people receiving information. For example, when the SAS counsellor does not know the person who is seeking information, they must be confident that the person is who he or she claims to be before providing such information. Particular strategies may include the following:

- Enquiries made by telephone regarding information in relation to a client's contact with the SAS, or regarding the outcome of a visit, will only be responded to by verifying the identity of the caller or asking them to submit the request in writing.
- Client consent will be obtained prior to transmission of information where possible. A copy of that consent will be kept in the client's records
- Any client information sent via email is to be done in accordance with [Privacy Manual for Health Information](#). The SAS counsellor will ensure that they have the correct email address for any electronic communication. Encryption will be considered for emailed information.

Particular caution is required regarding sharing information from one family member to another. There may be issues of hidden domestic and family violence, family secrets or other pitfalls that a practitioner could make worse through not knowing the history. The SAS counsellor will not be a conduit to passing information between one parent or other family member and another without their direct involvement and consent.

<sup>45</sup> Please refer to Protocol for definition of domestic violence support services



Procedures will be in place to enable clients to have safe and secure access to their own files.

### **22.2.5 Subpoenas**

SASs and their district/network will respond to subpoenas related to SAS clients in accordance with the NSW Health policy directive [Subpoenas](#) paying particular attention to whether Sexual Assault Communications Privilege applies ([Section 22.2.6](#)).

SASs must comply with subpoenas, while taking steps to protect individual's rights to confidential communications and sensitive material. SASs and other relevant district/network staff will attempt to contact the client (or family if appropriate, e.g. for children) to advise their records have been subpoenaed. When the person is a current SAS client, their SAS counsellor will usually be the appropriate person to inform them of the subpoena. If contact can be made, the client will be advised of what is covered by the subpoena and the location and date of return of the subpoena. Care is to be taken that the records are not inadvertently provided before that date, as the client may wish to object to the subpoena.

If a SAS has concerns about the scope of a subpoena, or considers it may be challenged, they are to consult their immediate manager. Where a SAS has concerns about a subpoena or the records that are to be produced, they will contact legal services within their district/network and/or Legal at the Ministry of Health.

### **22.2.6 Sexual Assault Communications Privilege (SACP)**

SACP is a protection for counselling communications to or about a victim or alleged victim of a sexual assault offence, from being used as evidence in criminal proceedings, including those related to Apprehended Violence Orders (AVOs), regardless of when that counselling may have occurred. Further information, including guidelines that apply to NSW Health staff in relation to SACP and suggested steps to deal with subpoenas that can contain SACP, is provided in the policy directive [Subpoenas](#), particularly Appendix A. Legal at the Ministry of Health can also provide specific advice in individual cases.

If information is exchanged under Chapter 16A of the [CYPCP Act](#) or Part 13A of the [Crimes \(Domestic and Personal Violence\) Act 2007](#), the district/network will consider whether requests for information about which the SACP may apply can be met providing a summary of information, rather than complete counselling records. If complete records are provided, the SAS or their district/network will inform the prescribed body that a SACP may apply, including to any future third party claim for the information provided by NSW Health. Additionally the record is to be marked as confidential and not be further disclosed unless it is necessary for purposes the information was shared under 16A or 13A, or as required as by law. See [http://www.community.nsw.gov.au/kts/guidelines/info\\_exchange/info\\_index.htm](http://www.community.nsw.gov.au/kts/guidelines/info_exchange/info_index.htm) for further information and examples of letters.

In relation to subpoenas where SACP applies, in addition to the steps about subpoenas noted in the section above, SASs will:

- Have local procedures in place for responding to subpoenas involving SACP that are consistent with the NSW Health policy directive on [Subpoenas](#).



- Have a register to record all subpoenas received by the SAS, which includes specifically identifying subpoenas about which SACP may apply (see [Subpoenas](#)).
- Take steps to protect confidential counselling communications from being disclosed where disclosure would potentially harm the client.
- Attempt to contact the client and advise their records have been subpoenaed and SACP applies in case they wish to waive their privilege. The SAS counsellor will advise the client of Legal Aid's [Sexual Assault Communications Privilege Service \(SACPS\)](#) and facilitate a referral to this service to enable the client to obtain free legal advice and representation. The SAS will also provide the client with the Legal Aid fact sheet [their privacy is your priority](#).
- Where information that may be covered under SACP is provided verbally, for example in JCPRP meetings, the SAS counsellor must state that the information is sensitive, may be subject to SACP, and will only be further disclosed within the partner agency where necessary and noting that SACP may apply.
- If Legal Aid's [SACPS](#) is not involved and the client or SAS believes the records subpoenaed should be protected, consider engaging the Crown Solicitor's Office (CSO) to act.

## 23 GOVERNANCE AND MANAGEMENT

### 23 Governance and management: summary

- Each SAS is managed by its host district/network and will have a management structure in place that clearly delineates the lines of responsibility and accountability of SAS staff consistent with the [Guide to the Role Delineation of Clinical Services](#).
- SASs require specific facilities and physical environments to provide their suite of services, and these can be divided into two main types: 1) SAS facilities for 24-hour crisis response; and 2) SAS facilities for normal business hours responses.
- SASs are required to undertake a range of quality improvement and monitoring activities in accordance with statewide and local requirements, which include, but are not limited to, data collection, reporting, service planning, evaluation, and complaints handling.
- SASs will adhere to specific requirements listed below concerning safety, security and ethical behaviour.
- SAS will be staffed sufficiently to meet local demand and, at a minimum, each Level 4 SAS will employ the following, each of which have identified roles and responsibilities, minimum professional qualifications, and training requirements:
  1. a SAS manager or clinical lead
  2. a medical director
  3. SAS counsellors (business hours staff and on-call roster) — ideally at least one SAS counsellor will be an identified Aboriginal position.
  4. a key contact point for children with PHSB
  5. medical and forensic examiners (on-call and/or on staff in business hours).
- SASs will provide professional supervision, performance appraisal, and professional development for their staff and, where possible, student placements.

#### 23.1 Service management

Each SAS is managed by its host district/network and will have a management structure in place that clearly delineates the lines of responsibility and accountability of SAS staff. The management structure of SAS will reflect the current senior leadership structures within the district/network in accordance with the [Guide to the Role Delineation of Clinical Services](#) ([Appendix 6](#)). It may also include dual reporting that reflects both SAS service line management and clinical supervision or reporting relevant to specific professions (e.g. medical, nursing, social work, psychology, etc.).

#### 23.2 Facilities and physical environment required for a SAS

A key principle underpinning the delivery of integrated and trauma-specific services is that clients and their families/significant others are to be treated with dignity, respect and sensitivity. The facilities and physical environment provided for SASs must ensure physical and emotional safety, and avoid replicating any elements of the initially traumatising experience (Kezelman & Stavropoulos, 2012, p. 89). In this context, clinical space is as much a part of the therapeutic

process as the therapeutic model used by the clinician, and so care and attention is to be provided to ensure it is appropriate. In particular, facilities will be accessible, secure, clean and private (WHO, 2003, p17).

Better outcomes are achieved from providing the right care in the right place at the right time for a range of healthcare services.

The crisis response to a disclosure or presentation of recent sexual assault or a client in crisis will be provided within, and in collaboration with, the ED ([Sections 5](#) and [14](#)), as these presentations require a 24-hour response, including ED triaging and treatment of any urgent medical needs, followed by provision of an integrated psychosocial and medical and forensic response by a SAS within the ED. This setting is also necessary for all types of SAS crisis responses for the security and safety of clients and staff, as the ED provides both 24-hour staffing and has the capacity to quickly respond to a medical emergency if the client unexpectedly deteriorates or another safety incident occurs (e.g. aggression or violence).

Integrated psychosocial and medical responses for sexual assault that was more than seven days ago (especially for children) and follow-up psychosocial and medical responses will ideally be provided in a dedicated SAS rather than the ED to help maximise privacy and comfort depending on the circumstances. This care will usually be provided in a community or ambulatory setting unless considered inappropriate for safety, quality of care and efficiency reasons. These services will be provided in an environment that is physically safe, welcoming and addresses the privacy needs of the client. The SAS may be situated in an outpatient clinic or community health centre, or, alternatively, these services may be provided through outreach responses to other health and community services or in the client's home ([Section 13.2.2](#)) depending on the circumstances. The SAS will have negotiated access, or procedures for negotiating access, to additional safe spaces away from the SAS in circumstances where SAS staff have concerns for the safety of other clients or SAS staff.

### **23.2.1 SAS facilities for 24-hour crisis responses (preferably in EDs)**

Districts/networks will provide the following facilities for SASs that are preferably within EDs or, at a minimum, located very close to the ED:

- separate designated (and if possible dedicated) SAS interview/counselling and medical and forensic examination rooms that are either attached to, or at a minimum, very near each other and are preferably within the ED. The rooms must meet the safety specifications set out in [Protecting People and Property — NSW Health Policy and Standards for Security Risk Management in NSW Health Agencies](#).
- safety and security measures, including 24-hour monitoring and duress alarms. The positioning of SAS rooms is to provide for good natural surveillance within the ED to ensure SAS staff are not physically isolated from other ED staff. All staff working in EDs in any capacity must carry a personal duress alarms at all times when on duty.
- easy access to a toilet and bathroom/shower facilities that are suitable for use by someone with a disability and that are preferably dedicated for SAS use to reduce contamination risk
- comfortable furniture that is washable and age appropriate, soft lighting and adequate temperature control
- easy access to a kitchen with fridge, tea/coffee and basic refreshments

- a table and chair for staff to write up documentation and which includes: a networked computer, internet access, telephone, and access to appropriate stationery, a printer, a photocopier, and a scanner. These facilities would ideally be available in both the interview and examination rooms where possible.
- the necessary equipment and space listed in [Section 15.8.3](#), which includes, but is not limited to, access to blankets, bed linen, patient gowns, and medical equipment that are free of DNA as well as sterile water
- necessary paperwork including:
  - MFER and Child Sexual Assault Medical Protocols
  - registration, clinical case notes and other relevant local forms for file notes
  - forensic register ([Section 15.14.3](#))
  - information and handouts for clients
  - current NSW Police *Guidelines for the collection of forensic specimens from complainants and suspects*
  - referral information and contact details for other agencies (may be digital).
- adequate storage and the provision of new clothing, where the victim's clothing has been collected for the medical and forensic examination, towels and toiletries (e.g. soap, toothbrushes, combs) to enable the client to shower/clean themselves
- facilities for the medical and forensic examination, including an appropriate fridge for cold storage of 'wet' trace evidence, which meet the requirements listed in [Section 15.8.3](#)
- where possible, access to larger break-out rooms for larger family groups, support people, and/or multiple victims presenting at one time.

### **23.2.2 SAS facilities (for normal business hours responses).**

SAS will provide:

- premises that respect the privacy, confidentiality, safety, comfort and needs of the client at all times
- waiting rooms that are supervised/staffed (visual and auditory) by at least one NSW Health or other agency staff member (in the case of outreach to another agency). This supervision may be by administrative/reception staff. There is also to be controlled access between public/waiting areas and clinical spaces.
- interview/counselling rooms and waiting areas with good temperature control, age-appropriate furnishings and toys and equipment in order to create a comfortable and child focused environment as well as dual egress to eliminate entrapment.
- premises and facilities, including toilets, that are accessible for people with disability
- where possible, at least one medical examination room within the SAS that has appropriate facilities and equipment to provide priority business-hours integrated psychosocial and medical responses (e.g. for children sexually assaulted more than seven days prior) and follow-up medical care

- office space with all the necessary equipment (e.g. computers, telephones, desks) for SAS staff (psychosocial and medical and forensic) to write case notes, undertake casework (including referrals and advocacy), prepare reports (including expert certificates), follow up any results of non-forensic testing, and participate in administration and managerial activities. SAS staff are to have access to a space to be able to have confidential conversations concerning clients if this office space is shared with other NSW Health staff, but this may be shared space with other SAS staff, as confidentiality is considered to be with the SAS itself and not the individual SAS staff member.
- space for the appropriate and secure storage of SAS client records away from the general medical record ([Section 22.1.4](#)).

### 23.3 Data collection and reporting

SASs will be guided by relevant NSW Health policy directives, information bulletins, and guidelines outlined below in relation to data collection and reporting:

- [Registration of NSW Health Establishments](#): describes the mandatory requirement to register health establishment locations and service units within NSW, record the registration details in NSW Health's Health Establishment Registration Online (HERO), and to release an extract to HealthDirect Australia to populate the National Health Service Directory.
- [Client Registration Policy](#): specifies NSW Health policy in relation to the registration of clients, patients and other related people.
- [NSW Health Client Data Stream Data Dictionary](#): outlines the data elements and classifications for collection, as represented within the Client Shared Dimensions of the Enterprise Data Warehouse (EDW).
- [Individual Service Provider Data Stream](#): outlines the data elements and classifications for collection, as represented within the ISP Shared Dimensions of the Enterprise Data Warehouse (EDW).
- [NSW Emergency Department Data Collection \(EDDC\) Reporting and Submission Requirements](#): outlines the scope, governance and reporting and submission requirements for the data collection for patient presentations to, and the activity undertaken in, EDs.
- [Non-Admitted Patient Activity Reporting Requirements](#) and [Non-Admitted Patient Data Collection: Reporting requirements for services provided from 1 July 2019](#): informs NSW Health service providers and source system administrators of changes to the classification and code set standard for reporting non-admitted patient services provided in an EDWARD extract format.
- **Other NAP resources:**
  - [Non-Admitted Patient Reporting Rules](#)
  - [Non-Admitted Patient Establishment Type Definitions Manual](#)
  - [Non-Admitted Patient Classification Principles](#)
- **Interim statewide data collections:** Interim statewide data collections are required in some instances to allow monitoring and reporting of health services to assist service planning, although they are not mandated by policy. Data collection and reporting arrangements may be discussed with district and network Chief Executives, and/or PARVAN senior executives

as required. Data may include patient, staff, workforce, organisation, or financial information. While these interim data collections do not meet the definition of a statewide data asset and are not strictly governed by the NSW Health Data Governance Framework, they are to seek to adopt best practice approaches and adhere to NSW Health Data Management Principles wherever possible.

- **Whole of Government Reforms:** A number of reporting requirements are emerging as a result of the NSW Government's response to the Royal Commission into Institutional Responses to Child Sexual Abuse, and other cross government initiatives including Their Futures Matter reforms, *NSW Sexual Assault Strategy*, NSW Ombudsman's review of the JIRT (now JCPRP) Partnership, and *NSW Domestic and Family Violence Blueprint for Reform 2016-2021*. These reforms may result in interagency monitoring and reporting frameworks being established to which NSW Health reports.

### 23.3.1 Service agreement key performance indicators, improvement measures and accountability

The Key Performance Indicator (KPI) and Improvement Measure Data Supplement has been developed to support districts and networks in monitoring and reporting on service agreements by providing the relevant information concerning the calculation of the indicators, as well as other improvement measures as monitored by various Ministry branches. This is updated annually.

Each district/network provides the Ministry of Health with routine data against KPIs and improvement measures, including related to SASs, related to district/network service agreements for the purpose of performance monitoring and service improvement.

### 23.4 Service planning and evaluation

Each SAS will conduct service planning on an annual basis. Service planning will:

- involve all staff
- take a strategic approach that is informed by statewide approaches to integrated care, including the [Strategic Framework for Integrating Care](#) and [IPARVAN Framework](#), the district's/network's strategic plan and other relevant strategic documents, and service evaluation and review activities
- enable service delivery that is responsive to the changing needs of the community and is of an appropriate standard, demonstrated through quality assurance mechanisms
- include an Aboriginal Action Plan ([Section 21.1](#))
- develop priorities and directions for the coming 12 months
- take into account [Value Based Healthcare](#) by planning to deliver services that improve the health outcomes that matter to patients, the experience of receiving care, the experience of providing care, and the effectiveness and efficiency of care
- include a workforce plan with attention to operational, tactical and strategic planning and which takes into consideration service delivery requirements, models of care and building on workforce capabilities



- ensure SAS staff have knowledge of local and state issues that arise in the fields of sexual assault (of adults and children) and consult at local and state levels to ensure planning is well-informed.
- be undertaken in conjunction with other relevant district/network staff.

In addition to service planning, each SAS will:

- participate in, and contribute to, district/network planning processes and service evaluation, and plan training (particularly for SAS managers or clinical leads and medical directors).

#### **23.4.1 Continuous quality improvement**

Each SAS will:

- Use effective and responsive methods to assess and improve the quality of their activities, and integrate with their planning and evaluation processes.
- Participate in relevant reviews such as for the National Safety and Quality Health Service Standards (NSQHS) and Quality Improvement Program (EQulP), and specific SAS service reviews by the Ministry of Health or district/network.
- Adhere to the NSW Health [Patient Safety and Clinical Quality Program](#).

#### **23.5 Complaints**

SASs will be accountable, and this includes ensuring that clients have the right to question, in an informal or formal way, the interventions, services and other responses they receive. Similarly, services, community members and others involved with SASs may also make a complaint. Even when the feedback is not in the form of a complaint, SASs must ensure they are open to receiving feedback to inform future service provision.

SASs will have formal processes for documentation and investigation of complaints to ensure appropriate action is taken and an early response given to the complainant. SASs will adhere to the [Complaint Management Policy](#) and [Complaint Management Guideline](#). Where the complaint relates to a child protection report, and there are safety concerns for family members or the reporter, details of people at risk are to be de-identified in the client file to help protect their safety.

If the complaint concerns a particular SAS staff member (as opposed to, for example, SAS policies or approaches generally), policies on [Managing Complaints and Concerns about Clinicians](#) and [Managing Misconduct](#) will be consulted (see also [Section 4.3](#)).

SAS clients have rights under the [NSW Charter of Victims' Rights](#), including their right to be informed about the complaints process if they perceive that their rights have not been met. SASs will inform their clients about the charter, and refer them to the [Charter of Victims' Rights complaints process](#) if they have complaints about the NSW Health services they have received that have not been resolved.

## **23.6 Human resources**

### **23.6.1 Safety and security**

The district/network and SAS manager or clinical lead will ensure the safety and security of both staff and clients in accordance with the NSW Health policy directive [Work Health and Safety: Better Practice Procedures](#). SASs will:

- identify and manage risks to secure and protect the health, safety and wellbeing of all members of staff, clients and stakeholders
- have a comprehensive work/health/safety framework in place to minimise risks to health, wellbeing and safety and to manage incidents promptly
- ensure that initial contact with clients is conducted in the premises of a designated office or patient treatment area or other safe environment and any outreach is provided in accordance with the guidance in [Section 13.2.2](#)
- install duress alarms where possible
- have protocols in place to manage risk for SAS staff travelling out of the office, which include procedures to inform other staff of proposed visits and expected times of return.

SAS staff are not to wear district/network uniforms that identify which specific service they are from due to risks and disadvantages, including work, health and safety, and privacy reasons.

SASs will implement the [Protecting People and Property — NSW Health Policy and Standards for Security Risk Management in NSW Health Agencies](#), which outlines a range of things, including minimum standards for health care facilities, home visits, after-hours visits, emergency procedures and car breakdowns.

In relation to personal details:

- SAS staff will exercise care in protecting the personal details of all clients and staff members.
- Personal contact details and home addresses of SAS staff will be kept in a secure location and not provided to any individual or agency without the express permission of the relevant staff member.
- All SAS staff will ensure their personal belongings or identifying information are kept secure at all times. This includes passwords for computers and not leaving valuables or confidential information unsecured.
- Any circumstance where the personal information of SAS staff has been or may have been obtained by any individual will be immediately reported to the staff member and the SAS manager or clinical lead.
- Any circumstance where personal details of a client have been or may have been obtained by any individual will be reported immediately to the SAS manager or clinical lead.

### **23.6.2 Ethical behaviour**

SASs are committed to ethical and accountable practice in a context where their work involves direct services to clients and communities, the possession of sensitive material, and a position of

power and authority over clients. Accordingly, SAS staff will adhere to the relevant NSW Health policies, particularly:

- [NSW Health Code of Conduct](#)
- [Conflict of Interest and Gifts and Benefits](#)
- [Communications — Use & Management of Misuse of NSW Health Communications Systems](#).

SAS staff are encouraged to be aware of any further requirements for personal and professional behaviour of the district/network as well as their relevant professional bodies, such as Australian Psychological Society, Australian Association of Social Workers, and Australian Health Practitioner Regulation Authority, Australian Counsellors Association, the Child Sex Offenders Counsellor Accreditation Scheme (run by the NSW Children's Guardian), and, for medical and forensic examiners, their relevant registering authority and medical colleges as appropriate.

If any SAS staff member encounters a situation where guidance is not provided by the above policies, they will consult with their line manager, such as the SAS manager, clinical lead or medical director as appropriate, at the first opportunity. Specific circumstances of particular relevance to SAS staff are also identified below.

### ***Relationships with clients***

SAS staff will:

- adhere to ethical personal and professional behaviour at all times and will not exploit their clients in any way
- not conduct sexual relationships or have sexual contact with clients, former clients or clients' immediate family/significant others.

Staff who have a pre-existing social or professional relationship with a client referred to the service will inform the SAS manager or clinical lead of the relationship and complete a risk assessment. Where indicated, an alternative worker must be found. Where there is a sole SAS counsellor in a particular area, the district/network is responsible for ensuring that the client receives the service from an alternative counsellor.

Where pre-existing social or professional relationships exist due to the small size of the community and/or an alternative counsellor is not available, SAS managers or clinical leads must have systems in place to ensure that professional boundaries are maintained.

SAS staff will address boundary issues as they arise and discuss them with their SAS manager or clinical lead. Boundary violations in a therapeutic relationship may include:

- going substantially over agreed length of time in sessions
- holding meetings outside appropriate office times or venues
- volunteering inappropriate personal information
- benefiting economically from a relationship
- social contact, and contact on social media

- sexualised behaviour.

Regular supervision, consultation and professional development help prevent boundary violations and maintain ethical standards (Sections [23.6.6](#) & [23.6.7](#)). Decisions regarding boundary violations will be implemented and monitored closely by the SAS manager or clinical lead.

### ***Giving or receiving gifts***

All SAS staff must comply with the NSW Health [Conflict of Interest and Gifts and Benefits](#) policy.

SAS staff will not give gifts to clients of the service except token gifts, for example small gifts to participants in group work or minimal cost gifts and cards given following clinical discussion (i.e. for special and planned purpose, linked to counselling).

From time to time, clients may give gifts to staff. Those gifts may be accepted provided they are not of a substantial value and no perception or suggestion of privilege is associated between giver and receiver.

### **23.6.3 Staffing profile and responsibilities**

SASs will be staffed sufficiently to meet local demand and, at a minimum, each Level 4 SAS will employ:

- a SAS manager or clinical lead
- a medical director
- SAS counsellors (business hours staff and/or after hours)
- a key contact point for children with PHSB
- medical and forensic examiners (as business hours staff and/or on-call staff to participate in urgent medical and forensic consultations and follow up medical care where possible and where this role isn't provided by the medical director).

Any of the staff listed above may provide outreach services either permanently or intermittently at different locations across the district/network.

Ideally, at least one, and preferably more than one, SAS counsellor in the district/network will be an identified Aboriginal position. Districts/networks will link in Aboriginal staff in SASs with workers funded under the [Aboriginal Family Health Strategy](#). Where SASs do not currently have any Aboriginal staff, the SAS manager or clinical lead will develop and implement a plan to recruit and retain Aboriginal staff as part of their Aboriginal Action Plan ([Section 21.1](#) & [Appendix 9](#)) and pay particular attention to interim strategies to ensure appropriate Aboriginal cultural consultation ([Section 21.4](#)), which may include Aboriginal workers from outside of the SAS participating in team meetings and clinical activities such as case reviews.

### ***SAS manager or clinical lead***

The SAS manager or clinical lead manages day-to-day operations of the SAS and is responsible for:

- effective oversight of psychosocial staff and management of the SAS, including compliance with policies, standards and procedures, and intersection of the SAS with the JCPRP. This

includes ensuring, in collaboration with the medical director, the integration of psychosocial and medical or medical and forensic responses working in the best interests of the client. It also means leading service planning for the SAS ([Section 23.4](#)).

- ensuring safe systems of work are in place and used by all SAS staff
- administration of the SAS, including managing the service budget, the preparation of annual reports and submissions and liaison with appropriate administrators on issues relevant to the service. It also involves overall coordination of crisis services, and the coordination and line management of the full suite of psychosocial services offered by the SAS (as outlined in [Section 12.1](#)), as well as liaison with medical and nursing staff. This includes ensuring appropriate coverage of daytime services and the availability of a roster of on-call counsellors for crisis response.
- provide case management and line management supervision and support to psychosocial and other (non-medical and forensic staff) as appropriate. This includes ensuring these staff are provided training, clinical supervision, debriefing and management support as required. It also means ensuring procedures are in place for SAS counsellors to contact senior district/network staff for urgent advice, including after hours and providing clinical supervision to staff if it is not possible, or not preferable, to contract an external supervisor ([Section 23.6.6](#)).
- collection of data relevant for future planning of service provision. This includes ensuring completion and submission of NSW Health data collection forms ([Section 23.3](#)).
- limited direct service role where appropriate as per SAS counsellor (see below)
- liaison with other relevant services, departments and agencies both within and outside the district/network and the resolution of complaints and problems
- ensuring a balance of local professional consultation and training ([Section 19](#)) and community education, education and prevention ([Section 20](#)) by the SAS
- ensuring that the service consults with local agencies, communities, peak bodies/interest groups in order to maximise access and sensitivity to special needs groups and priority populations
- oversight of counselling records management, responding to subpoenas and provision of legal and other reports
- monitoring of quality assurance activities.

### ***Medical director (senior medical officer)***

Districts/networks will appoint a designated medical director with responsibility for the overall coordination and quality assurance of the medical and forensic components of the SAS. The medical director will work in accordance with the principles and procedures outlined in this document and in collaboration with the SAS manager or clinical lead. A district/network may appoint a SANE to provide overall coordination and management of the medical and forensic response to sexual assault. However, in such circumstances a medical director must still be identified to provide medical mentoring and support for that SANE within that district/network. The medical director's responsibilities are detailed in [Section 15.1.4](#).

## **SAS counsellors**

SAS counsellors' responsibilities include (but are not limited to):

- Provide the full range of psychosocial client services and activities of the SAS including: service access ([Section 13](#)); crisis response, including overall coordination of the crisis response and provision of its psychosocial components ([Section 14](#)); ongoing therapeutic interventions for sexual assault ([Section 16](#)); court preparation, court support and reports ([Section 17](#)); systems advocacy ([Section 18](#)); professional consultation and training ([Section 19](#)) and community engagement, education and prevention ([Section 20](#)).
- Provide trauma-specific, integrated, holistic, and culturally safe care.
- Work within a multidisciplinary SAS.<sup>46</sup>
- Participate in training, continuing professional development, and other skill development activities related to their role with the SAS.
- Participate in quality assurance processes, such as regular peer review, clinical supervision, debriefing and staff meetings, as well as in research where appropriate.

## **Key contact point for children with PHSB**

Each district/network will appoint a single key contact point for children with PHSB in a SAS. The responsibilities of this key contact point also include (but are not limited to):

- establishing and promoting local referral pathways for this client group
- coordinating the program model, including referrals, intake, assessment, care and service responses to children with PHSB in accordance with the NSW Health policy on the Children's Sexual Behaviour Program
- limited direct service provision for children with PHSB and their families/significant others
- build capacity within and outside the health system to better respond to children with PHSB. This may include facilitating professional development opportunities, providing support and supervision, and providing debriefing for SAS counsellors and other services in local referral pathways (e.g. CPCS and CAMHS).
- coordinate systems advocacy and prevention and community education activities focused on children with PHSB in accordance with the NSW Health policy on the Children's Sexual Behaviour Program

## **Medical and forensic examiners**

Medical and forensic examiners provide medical or medical and forensic services to victims of sexual assault. Their responsibilities are detailed in Section 15.1.1.

## **Availability and payment of SANEs**

To practice in NSW Health services in a capacity secondary to their primary employment in NSW Health, SANEs must have approval in accordance with statewide and local secondary employment policies and secure leave from performing other duties, including participating in after

<sup>46</sup> As noted in Section 1, the term SAS used here refers to Sexual Assault Services, Child Protection Units and Integrated Violence, Abuse and Neglect (VAN) Services that include principal responsibility for responding to sexual assault in their district/network.



hours on call rosters to provide this service. They need to be available to complete the medical and forensic examination as soon as is practicable following the presentation of a victim of recent sexual assault and within the mandated timeframes (within two hours of request by the SAS counsellor).

SANEs will need to prepare Expert Certificates or other reports related to the client's presentation at the SAS. It is the responsibility of the SANE's line management to organise rosters that create availability to enable the SANE to complete these reports as required and to ensure the SANE is available to attend at court if required.

It is the responsibility of the district/network to provide payment and conditions for SANEs in accordance with existing awards and/or local on-call arrangements.

#### **23.6.4 Professional qualifications for SAS clinical staff**

SASs will maintain an appropriately qualified workforce to ensure a high quality of service delivery and to align with best practice.

SAS counsellors will usually be qualified social workers or psychologists. All SAS counsellors will have appropriate tertiary qualifications in the behavioural sciences, such as social work, psychology or tertiary (bachelor's degree or higher) level counselling. Aboriginal counsellors or Aboriginal health workers who do not hold tertiary qualifications may be recruited on the basis of cultural expertise and will be supported to undertake training towards the required tertiary qualifications.

The SAS manager or clinical lead will have the tertiary qualifications as per SAS counsellors, as well as clinical experience in sexual assault, and management and supervision skills.

The professional qualifications and credentialing requirements for medical and forensic examiners, is at [Section 15.1.1](#).

#### **23.6.5 Learning pathways for SAS psychosocial staff**

Key elements of the learning pathways for SAS counsellors include orientation, mandatory and recommended training, and ongoing professional development.

##### ***Orientation***

Each SAS will provide a structured orientation program that all SAS staff are required to complete, which will cover agency policy and protocols, relevant work health and safety issues, expectation of workers, the agency profile, and partnerships with key stakeholders. This will vary across districts/networks. It is important that new workers understand the work environment before attending core training and delivering services.

##### ***Core and strongly recommended training for SAS counsellors***

Core training for SAS counsellors, managers and clinical leads is delivered by [ECAV](#). This training supports trauma-specific and trauma-informed, collaborative, and integrated responses to adults, children, young people and families with a focus on application of a socio-political and violence, abuse and neglect clinical practice framework when addressing the impact of sexual assault.

It is important to acknowledge the dynamic process in which practice and training changes and grows over time due to the complexity of the work, and the changing political and interagency landscape. For workforce development to be effective, the training identified below needs to be viewed in connection with ongoing workplace learning opportunities, peer support and clinical supervision ([Section 23.6.6](#)).

SAS counsellors are encouraged to attend the first available courses in Figure 15 below after commencing at the SAS. Additional ECAV training is strongly recommended for SAS counsellors as outlined in Figure 16 below.

Each district/network may identify additional training as core or strongly recommended for SAS staff based on local needs.

### ***Professional development for all SAS staff***

SAS staff will have the opportunity for ongoing professional development to assist their practice around emerging clinical issues in their respective fields of expertise. The workplace needs to support the integration of new knowledge and skills gained from training and professional development. Specifically, SAS will:

- allocate resources for the professional development and training of staff to assist in maintaining a knowledgeable and qualified workforce
- provide or support opportunities for SAS staff to access ongoing professional development, including attendance at conferences, workshops and participation in formal education programs
- ensure SAS staff are provided with appropriate training to assist in their roles
- ensure SAS staff attend continuing professional development and education to ensure clients' access to quality, skilled, competent, and non-judgmental services
- encourage ongoing development of management skills for SAS managers and clinical leads and for medical directors or senior medical officers which may include training in supervision, planning, service management, staff selection, information management and media contact.

Figure 15: Core training for SAS counsellors

Who	Training program
<b>SAS counsellors and managers/clinical leads</b>	VAN Graduate Certificate in Integrated Violence, Abuse and Neglect Interventions (Nationally accredited ASQA Qualification)
	Working therapeutically with children and young people who have experienced sibling sexual assault
	Interagency Forum: Advocating for and supporting children under 10 with harmful sexual behaviours. A family-focused response
	Foundations for working with children under 10 with harmful sexual behaviours: A family-focused model
	Developing culturally safe trauma informed practice in Aboriginal communities
	Practical Skills in Responding to People Who Have Experienced Domestic Violence
	Support to attend to the Violence, Abuse and Neglect Clinical Forums
<b>Aboriginal counsellors without formal qualifications</b>	Certificate IV in Aboriginal Family Wellbeing and Violence Prevention Work
	VAN Graduate Certificate in Integrated Violence, Abuse and Neglect Interventions
<b>Aboriginal counsellors with formal qualifications</b>	VAN Graduate Certificate in Integrated Violence, Abuse and Neglect Interventions
	Journey of Survival and Defining Healthy Boundaries

Figure 16: Strongly recommended training for SAS counsellors

Who	Training program
<b>Aboriginal counsellors without formal qualifications</b>	Advanced Diploma in Aboriginal Specialist Trauma Counselling and Graduate Certificate in Human and Community Services (Interpersonal Trauma Stream)
<b>Aboriginal counsellors with formal qualifications</b>	Certificate IV in Aboriginal Family Wellbeing and Violence Prevention Work
	Advanced Diploma in Aboriginal Specialist Trauma Counselling
	Graduate Certificate in Human and Community Services (Interpersonal Trauma Stream)

### 23.6.6 Supervision and support for all SAS staff

Supervision involves SAS staff consulting about their client work on a regular basis with a practitioner, usually one who is more experienced than themselves (Kezelman & Stavropoulos, 2012, p. 98). It provides opportunities for counselling, debriefing, assistance, mentoring and clinical development (Royal Commission, 2017, Vol. 9, p. 145). Supervision is important to underpin effective practice, to meet the needs of clients and for building and retaining a strong workforce.

A key strategy for maintaining ethical practice and monitoring the quality, safety and wellbeing of staff is to provide external professional supervision, ensuring opportunities for counselling, debriefing, assistance, mentoring and clinical development. (Royal Commission, 2017 Vol. 9, p. 145)

A culture of supervision and staff support is an essential component of workforce health and safety, and in particular it is vital for staff retention and staff support and wellbeing, to prevent burnout, and to mitigate the effects of vicarious trauma (Royal Commission, 2017 Vol. 9; Kezelman & Stavropoulos, 2012, pp. 18, 84, 98-9).

This section discusses what is necessary to support and build clinical capacity, identifies some of the safety and risk issues for SAS staff, and outlines the role and nature of supervision and other supports that enable the work to occur with intentional best practice. It has a particular focus on SAS counsellors but is also relevant for medical and forensic examiners. It is best be read in the context of broader NSW Health policy and other guidelines such as the Health Education and Training Institute's (HETI) [Superguide: A handbook for supervising allied health professionals](#) and the [NSW Health Clinical Supervision Framework](#), which include useful supervision resources such as templates for supervision agreements and other documentation.

#### ***Potential impact of the work on staff***

It is now well recognised that practitioners can experience trauma as a result of engaging empathically with traumatised clients and bearing witness to the traumatic events in their lives. Research has demonstrated that there are certain conditions that cause adverse impact for clinicians including:

- work stress: excessive pressures or demands
- burnout: feeling emotional exhaustion and reduced accomplishment
- trauma: direct experiences of a threatening event that overwhelms coping ability
- vicarious trauma (VT): when someone is impacted from their exposure to trauma content (Russ, Lonne, & Darlington, 2009).

There are high rates of VT (30-50%) in workers in child protection and related fields such as sexual assault (Bell, 2003; Conrad & Kellar-Guenther, 2006; Cornille & Meyers, 1999). There are also many professionals, including health workers, with their own histories of violence or abuse including sexual assault (McLindon, Humphreys, & Hegarty, 2018). These personal experiences may intersect with the professional practice of SAS staff and contribute to impacts, including VT. Notably, 50-70 per cent of workers do **not** suffer VT (Russ et al., 2009) and many workers demonstrate and/or develop resilience in the face of adversity (Russ et al., 2009), experiencing 'compassion satisfaction' (Figley, 1995). Things that help to protect practitioners from the effects of burnout and VT include:

- ensuring appropriate and diverse caseloads
- providing effective and regular supervision
- encouraging a culture of debriefing and providing appropriate forums for this debriefing
- staff and peer support and ongoing professional development
- encouraging critically reflective practice and critical reflection ([Appendix 4](#))
- building a workplace culture that negates the risks and experiences of vicarious trauma, embracing approaches to trauma-informed systems of care.

### ***Functions of supervision***

Supervision is a relationship-based activity that can enable clinicians to reflect upon their work. It 'provides a supportive, administrative and development context within which responsiveness to clients and accountable decision-making can be sustained' (Davies, 2000, cited in HETI, 2012, p. 6). It also provides an opportunity for critical reflection ([Appendix 4](#)). Supervision needs to meet a number of functions such as:

- **educational:** meeting the developmental needs of the SAS staff member by providing knowledge and skills, developing capacity for self-reflection and self-awareness and integration of theory and practice. This can include identifying learning needs and supporting access to training within the scope of their practice.
- **support:** ensuring the SAS staff member is supported in managing the stresses of the work, developing a professional identity and sustaining morale
- **administrative:** providing accountability, role clarity, management of workloads and addressing organisational issues (HETI, 2012).

Failure to ensure access to quality supervision and reflective processes can have detrimental effects for clients, practitioners and the health service, as has been demonstrated by numerous inquiries in Australia and overseas (Frederico, Jackson, & Dwyer, 2014; HETI, 2012; Munro, 2008). Consequences of inadequate supervision can include:

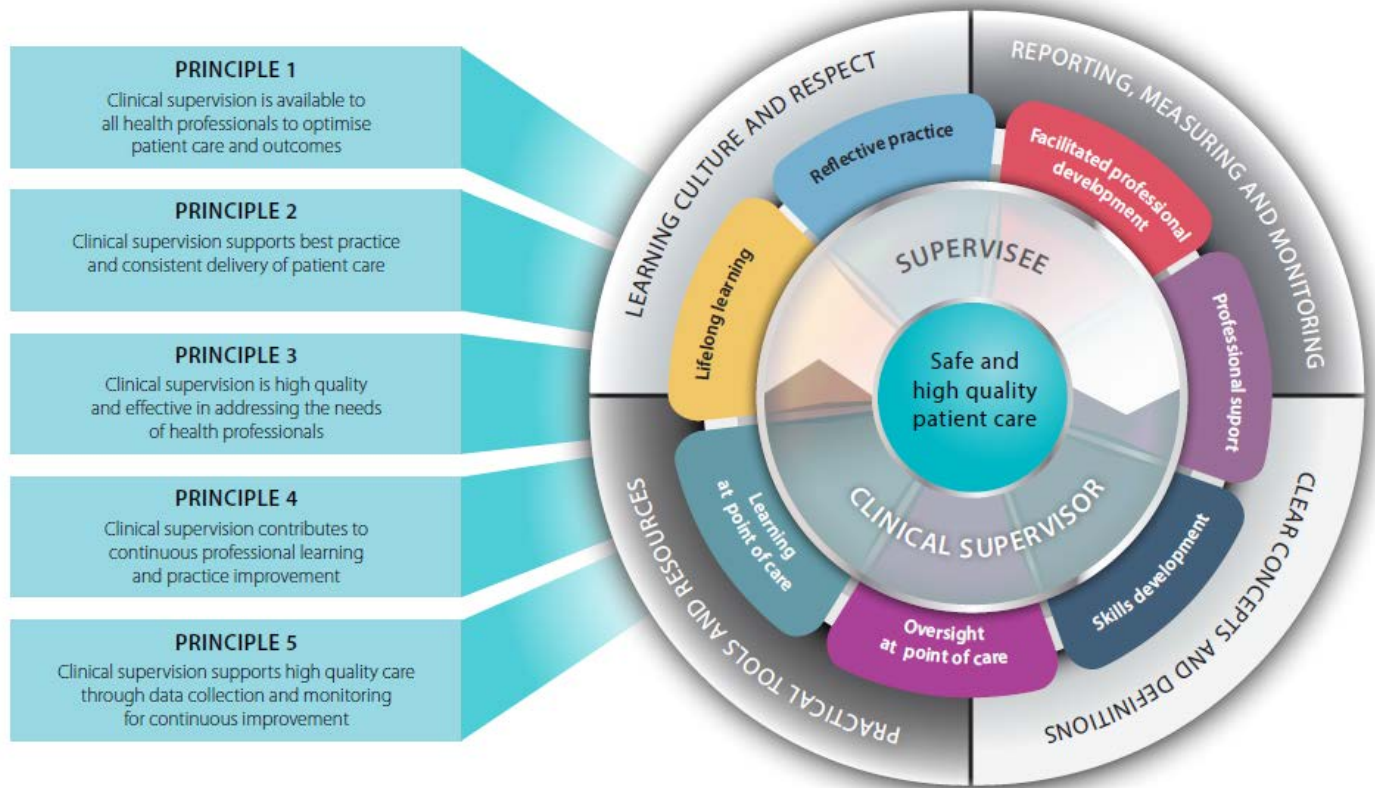
- problems in risk-assessment and case-planning
- lack of clarity in roles, goals and outcomes
- interagency conflicts
- difficulties managing priorities, waiting lists, and case closure, and
- worker stress, vicarious trauma and staff turnover.

### ***Provision of supervision***

The [NSW Health Clinical Supervision Framework](#), as illustrated in Figure 17 below, lists five core principles for clinical supervision. The Framework recognises the range of ways clinical supervision needs may be met.



Figure 17: NSW Health Clinical Supervision Framework (reproduced from [HETI](#))



Consistent with this framework, SAS will provide regular individual supervision and debriefing for all their staff. In general, supervision for SAS psychosocial staff will be provided as follows:

- The content and style of supervision will be negotiated on an individual basis, taking account of relevant needs for the circumstances, including: type of support, professional development, accountability, client-related issues, and profession specific needs (e.g. if the supervisor is required to have a specific professional qualification such as to meet registration requirements).
- A supervision agreement will be established at the commencement of the supervisory relationship (see the HETI [Superguide](#) for an example) that outlines purpose and scope of clinical supervision and roles, fees, responsibilities, confidentiality, ethics and recording requirements. This agreement will clearly articulate the frequency and duration of the supervision and will be consistent with requirements of a relevant award, registration or professional body (e.g. APRHA). As a general principle, supervision occurs no less frequently than monthly (pro-rata), at an agreed regular time and at an agreed location. The supervision agreement will be reviewed on a regular basis (at a minimum annually) and may include written feedback to the line manager at agreed intervals advising not of content, but of themes covered in supervision and any concerns they may have in relation to performance (as applicable) or areas of professional development that require support.
- Supervision may include individual supervision, group supervision and supervision by telephone or telehealth.



- Supervision will focus on reviewing counselling interventions, quality assurance, mentoring, developing clinical skills and reflection, and debriefing and assistance in the management of vicarious trauma.
- Supervision requires 'limited confidentiality', in that the specific content remains confidential between the supervisor and supervisee, unless there are ethical or quality concerns about the practitioner or their practice.
- Clients of the service need to be aware that the practitioner receives supervision and that their confidentiality is assured within the supervisory process.

Cross-cultural safety and support will be provided for Aboriginal and non-Aboriginal SAS staff. Cultural supervision with an appropriate Aboriginal consultant is particularly important for Aboriginal counsellors, as well as non-Aboriginal counsellors who have a high load of Aboriginal clients. Cultural supervision can also play an important role in working through personal and practice steps needed in working towards cultural competence ([Section 21.2](#)) for non-Aboriginal staff. It is to be undertaken by the whole SAS at regular intervals through the year.

Medical and forensic examiners also require access to clinical supervision. This may be provided through a group peer supervision, an individual session, or remotely by telephone, video link or webinar. Supervision for new examiners will occur on site at the time of the medical and forensic examination, and, for experienced examiners, at regular intervals determined by service need. In some cases, this supervision function can be provided by the medical lead. In other cases, alternate arrangements will need to be made by the district/network for supervision by an appropriately trained and experienced medical clinician. Provision must be made for medical and forensic examiners to access debriefing and support with vicarious trauma if requested, and this may require funding for access to external supervision.

### ***Accessing supervision in diverse settings***

A line manager may perform clinical supervision functions if suitably qualified to do so. However, these functions could also be undertaken by another suitably qualified supervisor (HETI, 2015). Given the specialist nature of the work undertaken by SASs and the location and capacity of some district/network sites, the required clinical supervision may not always be available within existing line management structures. This is particularly a challenge for rural and remote workers (HETI, 2012) and due to the use of multidisciplinary teams within health care, meaning supervisors may not always be of the same discipline. SAS counsellors, managers and/or clinical leads may also prefer separate line management and clinical supervision.

SAS managers and clinical leads need to have the necessary skills to enable them to meet the core functions of supervision and ensure staff have access to appropriate, quality supervision. The district/network has the responsibility to ensure these skills are made available if they are not accessible or not appropriate to be provided from within the SAS. This can be done through contracting an external provider for individual or group supervision, or making available another suitably qualified professional from within the district/network.

Where an external consultant is contracted to provide clinical supervision, they will always be responsible to the SAS manager or clinical lead (or medical director if the supervision is for medical and forensic staff) for their work within the service. They will also provide consultation

consistent with the policies and procedures of the SAS and of NSW Health, with particular attention to:

- [\*Child Wellbeing and Child Protection Policies and Procedures for NSW Health\*](#)
- [\*NSW Health Code of Conduct\*](#)
- [\*Managing Misconduct\*](#)
- [\*Child Related Allegations, Charges and Convictions against NSW Health Staff\*](#)
- [\*NSW Health Policy on Managing Complaints and Concerns about Clinicians\*](#).

### **23.6.7 Performance appraisal and professional development and review**

SASs are committed to providing meaningful and beneficial performance appraisal aimed at promoting the accountability and professional development of all staff. Formal performance appraisal or professional development review will be undertaken according to district/network and statewide requirements.

Performance appraisal is a structured and interactive process and includes comprehensive reflection, consideration, discussion and feedback. In the first year of service for all SAS staff, performance appraisal will take place not less than six-monthly. In subsequent years it will take place not less than yearly and in accordance with the staff member's contract, position description and/or performance agreement.

SAS will also adhere to the NSW Health [\*Managing for Performance\*](#) policy directive which identifies the key features to be reflected in all NSW Health organisations' policies on performance management, including requirements for managing unsatisfactory performance.

### **23.6.8 Student placement**

SASs will contribute to the education of tertiary students to increase their awareness and understanding of issues in relation to work concerning violence, abuse and neglect involving children.

Due to the sensitive nature of the work, a thorough assessment of the appropriateness of the student is essential for the protection of the student and clients of the service. SASs will adhere to the requirements in [\*Clinical Placements in NSW Health Policy\*](#) and [\*Guidelines for Clinical Placements in NSW Health\*](#) in relation to student placements and have written guidelines regarding student placements. These guidelines will include: supervisory arrangements; feedback mechanisms; confidentiality requirements; and development of a contract outlining the role of the student on placement.

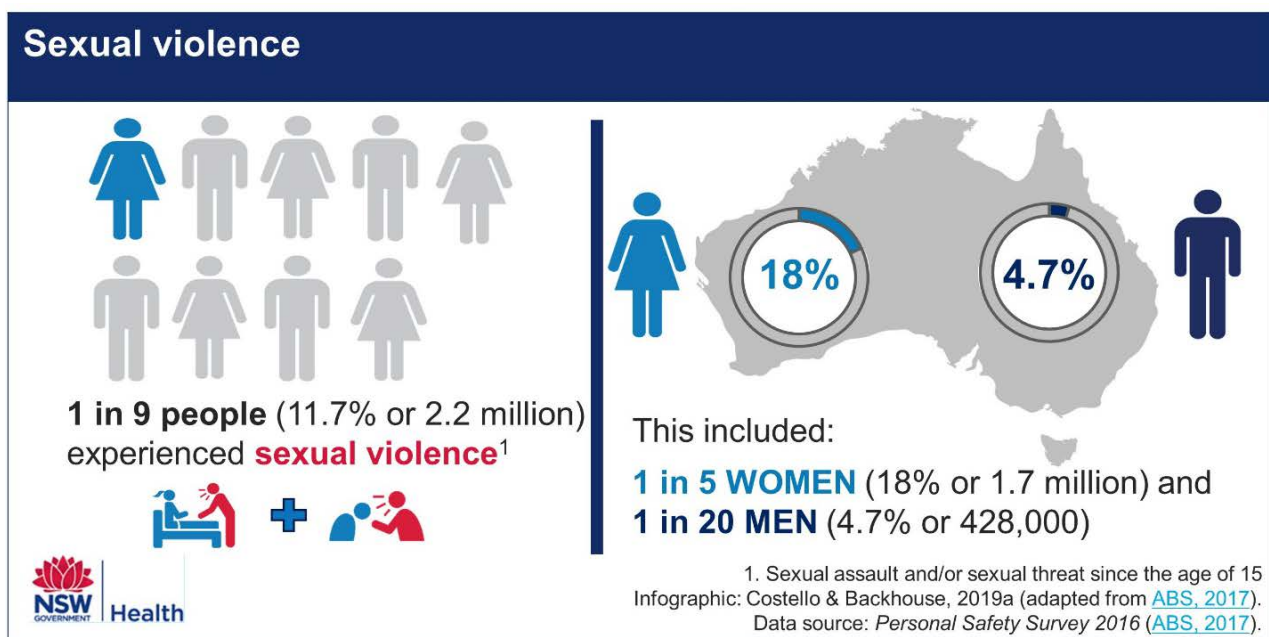
## APPENDIX 1: THE NATURE OF SEXUAL ASSAULT

The following appendix briefly outlines the key issues summarised in [Section 2.1.2](#), which are important to consider when providing health responses to people who have experienced sexual assault and their families/significant others.

### Statistics on sexual assault

Sexual assault is widespread in the Australian community, with many people affected, particularly women, young women and girls. Some of the slides on the statistics and research related to sexual assault and child sexual abuse from the [Integrated Violence, Abuse and Neglect Statistics and Research Project](#) are provided below. The slides reproduced and other slides (Costello & Backhouse, 2019b) as well as further information on violence, abuse and neglect statistics and research are available for use at: <http://www.ecav.health.nsw.gov.au/van-statistics-and-research/>

**Figure 18: Infographics on sexual assault** (reproduced from Costello & Backhouse, 2019b)

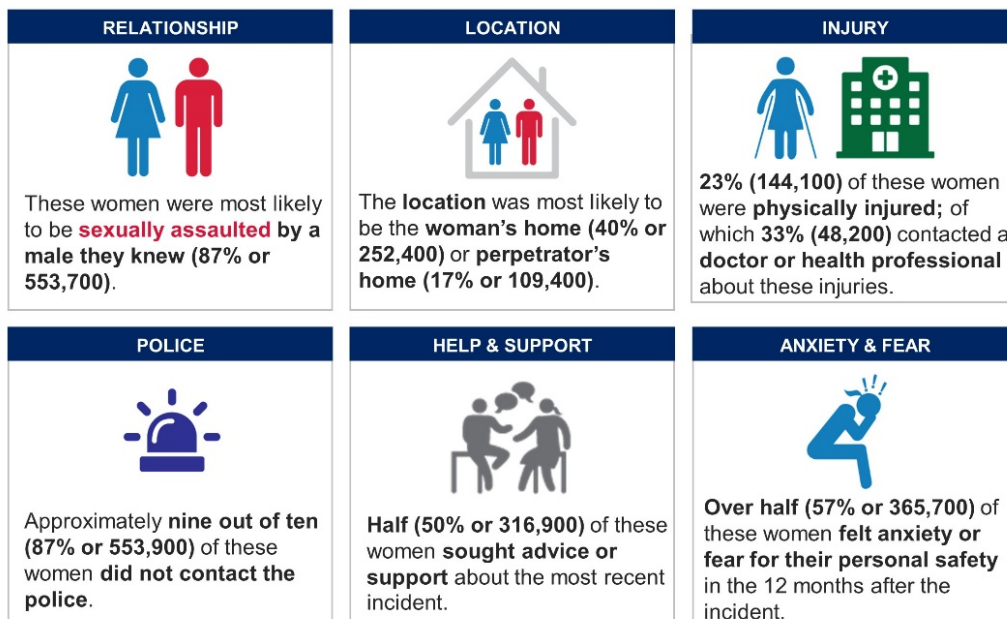


## Sexual assault



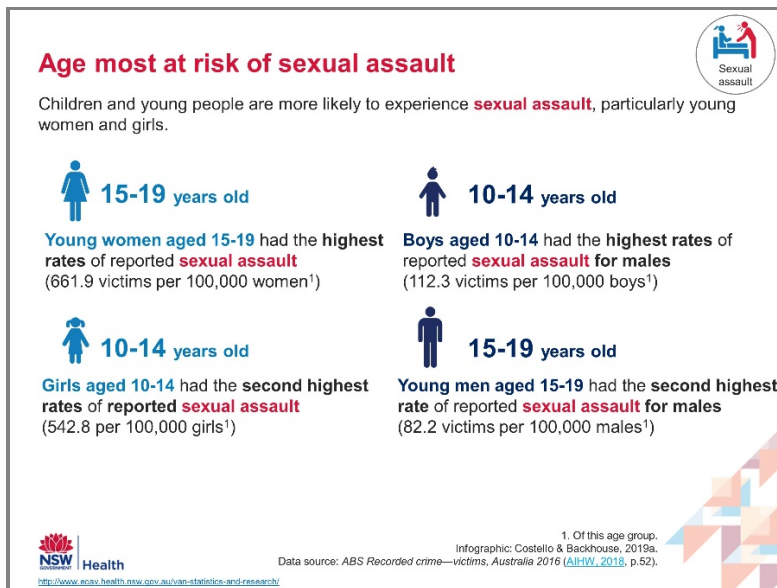
## Characteristics of sexual assault

In the most recent **sexual assault** of a **female**\* by a **male** in the last 10 years:

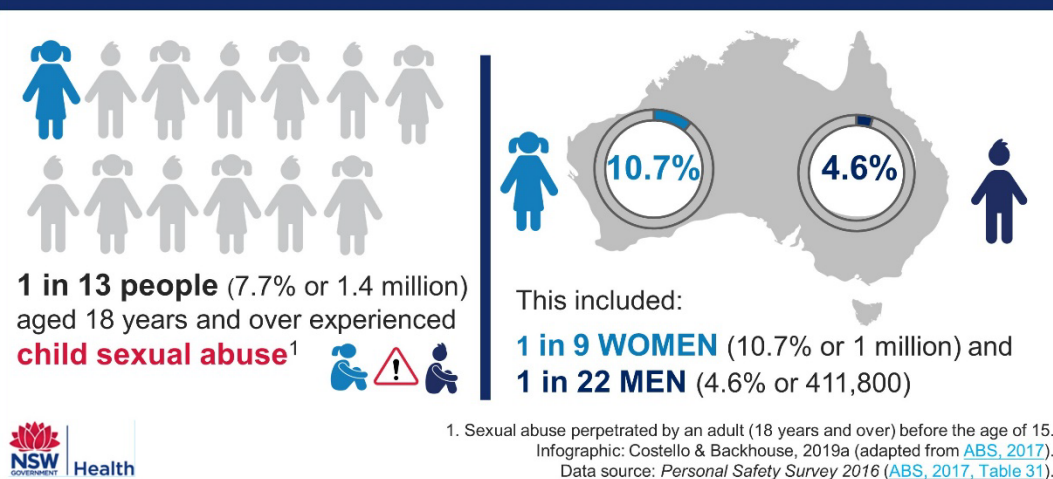


\* Comparative data is not available for men's experiences of sexual assault by a male or female or women's experience of sexual assault by a female as the data for these types of violence are not reliable enough to report due to their low prevalence.

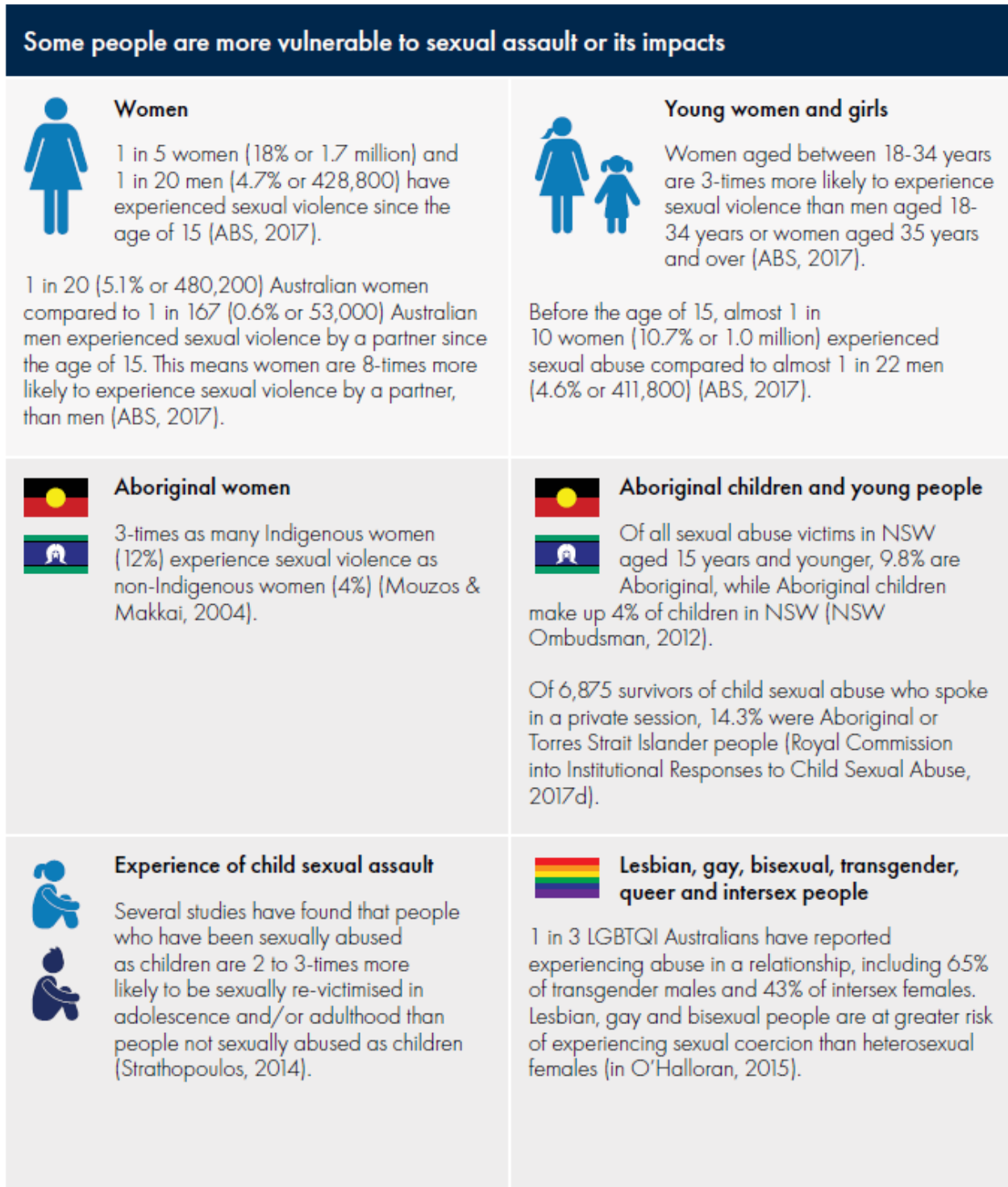




## Child sexual abuse



**Figure 19: Sexual assault statistics for particular population groups**  
(reproduced from: Costello & Backhouse, 2019a).







#### **Women with disabilities**

International research indicates that up to 70% of women with disabilities have been victim-survivors of sexual violence; and that up to 90% of women with an intellectual disability have experienced sexual abuse, more than two-thirds (68%) before they were 18 years of age

(Australian Law Reform Commission 2010, in Frohmader, Dowse, & Didi, 2015).

More than a quarter of rape cases reported by women in Victoria between 2000-2003, were perpetrated against women with disabilities (Heenan & Murray, 2006, in Frohmader et al., 2015).



#### **Children and young people with problematic or harmful sexual behaviours**

Australian studies show that 30-60% of childhood sexual abuse is carried out by children and young people, and most young people know their victim and target younger children or peers (Department of Human Services, 2012; Hunter 1999; KPMG, 2014, p. 22; Weinrott, 1996 – all cited in El-Murr, 2017).

Of survivors of institutional child sexual abuse that provided information in a private session to a Commissioner about the age of the perpetrator, most were abused by an adult perpetrator (85.2%), and 23.4% were abused by a child with harmful sexual behaviours (Royal Commission into Institutional Responses to Child Sexual Abuse, 2017b).



#### **People in correctional facilities**

People in correctional and juvenile justice settings often have histories of sexual victimisation (Clark & Fileborn, 2011; Crome, 2006; Royal Commission into Institutional Responses to Child Sexual Abuse, 2017a).



#### **Older women**

In Australia, 344 reports of 'alleged or suspected unlawful sexual contact' were made in residential aged care during 2011-2012 (Mann, Horsley, Barrett, & Tinney, 2014).



#### **Women experiencing domestic and family violence**

Since the age of 15, 5.1% (1 in 20 or 480,000) Australian women have experienced sexual violence (sexual assault or threat) by a partner they have lived with; and half of all female victims of sexual assault by a male since the age of 15, were sexually assaulted by an intimate partner (51% or 787,900) (ABS 2017).

International research shows that physically abused women who also experienced forced sexual activity or rape, were 7-times more likely than other abused women to be killed by their partner; and that sexual assault by a partner was the strongest indicator of escalating frequency and severity of violence, more so than stalking, strangulation and abuse during pregnancy (Campbell et al., 2003).

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## **Impacts of sexual assault**

The impact of sexual assault on the lives of people who experience it is multifaceted and complex and may include emotional, social, psychological, neurobiological, legal, health, spiritual, economic and political consequences. A growing body of research has demonstrated that sexual assault can have a range of immediate and lifelong effects on physical and mental health (see, for example, AIHW, 2018; Briere & Spinazzola, 2005; Cashmore & Shackel, 2013; Royal Commission, 2017; Sturza & Campbell, 2005; Ullman et al, 2005; Wadsworth & Records, 2013; WHO, 2013b).

Sexual assault impacts on people differently and the nature and extent depends on many factors such as:

- the relationship of the victim to the perpetrator
- the nature and duration of the assaults
- the reaction of significant people in the victim's network
- the presence or absence of family support and strong peer relationships
- the presence of other forms of abuse
- socio-demographic factors, specifically the impacts of systemic discrimination and disadvantage on Aboriginal and Torres Strait Islander, culturally and linguistically diverse, and LGBTQI people, people with disability and people experiencing poverty, homelessness and migration-related vulnerability.
- in the case of child sexual assault, the age of the child when the abuse started, other childhood adversities, whether a family member perpetrated the sexual assault, and the support the child received.
- the timeliness, quality and appropriateness of the service response.
- ability to establish safety
- court responses and outcomes.

The following are some of the most common impacts of sexual assault.

### **Immediate impacts**

In the immediate post assault period, victims can experience shock, denial, disbelief, numbness, fear and acute stress response/disorder. They may also be at risk of pregnancy and sexually transmitted infections or other communicable diseases. In addition, children, young people and adults who have been sexually assaulted often have fears about the impact of the abuse on their physical health and wellbeing.

### **Longer-term impacts**

Various potential longer-term negative health consequences and social impact of sexual assault for mental and psychological health and adjustment in childhood through to adulthood identified in the literature (e.g. Briere and Elliott, 2003; Briere & Spinazzola, 2005; Cutajar, 2010; Cashmore & Shackel 2013) include:

- emotional and psychological harm (e.g. recurrent daytime intrusive memories, flashbacks, anger/irritability, hyper-vigilance, nightmares, guilt, shame, low self-esteem, feeling betrayed, dissociation)
- poor mental health outcomes, (e.g. depression, anxiety, post-traumatic stress disorder, complex post-traumatic stress disorder, eating disorders)
- poor physical health (e.g. somatic complaints, chronic health issues) and physical symptoms of hyperarousal such as palpitations, sweating, breathing difficulties
- sleep problems
- sexual concerns (e.g. sexual distress or dysfunction)
- suicide, suicidality (ideation, plans and attempts) and self-harm
- alcohol and illicit and prescription substance abuse
- mistrust of people, interpersonal relationship difficulties (e.g. with partners and children) and negative impacts on families
- loss of interest in normal day-to-day activities
- feelings of isolation, stigmatisation, and poor self-esteem
- disruption to connection to culture
- disruption to education, vocational activities, employment and economic security
- engaging in behaviours associated with risk (e.g. unprotected sexual intercourse, offending behaviour, gambling)
- behavioural problems in children and young people
- exceedingly high expectations of themselves
- difficulties identifying and expressing needs
- higher risk of lifetime trauma and re-victimisation, especially following childhood sexual abuse.

The dominant framework through which the psychological responses to sexual assault are understood has been through a diagnosis of acute stress disorder (ASD) or post-traumatic stress disorder (PTSD). PTSD is commonly identified by three symptom clusters in the Diagnostic Manual of Mental Disorders (DSM-IV):

- intrusive memories (e.g. flashbacks, nightmares, emotional or physiological reactions to reminders. including images, smells, sounds and physical sensations)
- avoidance/numbing (e.g. avoiding reminders associated with the event, emotional numbing, loss of affect)
- hyper-arousal (e.g. exaggerated startle response, hyper-vigilance, irritability, sleep disturbances, concentration problems).

For adults with PTSD arising from their experience of sexual assault, the nature of the abuse experienced is highly variable, as is also the accompanying trauma responses. Consideration of sexual abuse history in terms of a recent assault or ongoing abuse, including childhood sexual

abuse, must be ascertained to ensure that a proper assessment of the struggles and needs of each individual victim is conducted.

### **Specific impacts of child sexual abuse**

Child sexual abuse may have serious psychological consequences arising out of deep violation of trusting relationships, extreme abuse of power, misplaced responsibility, and interruption of psychological and emotional development. It is common for people who have been sexually assaulted to experience difficulty in identifying and naming it as assault. This is particularly true for children and young people, who may not have the language or experience to identify what has happened to them as wrong or where sexual coercion and assault is being increasingly normalised in peer relationships. Many children who are sexually abused take years to disclose such abuse and some never do.

Disclosure of child sexual abuse is often a complex process and not a single event (ECAV, 2013). When they do disclose, victims who have been entrapped into secrecy often have many fears at disclosure, for example:

- that the specific events threatened by the perpetrator will occur
- that they will get into trouble
- that they will not be believed
- that they will be blamed.

Victims often have feelings of responsibility — for telling on a family member, for causing distress in the family, for breaking up the family. These and other factors, such as grooming by the perpetrator, mean these victims may recant and then possibly reaffirm the abuse happened (ECAV, 2013).

Disclosure of child sexual abuse is a crisis for the child and their family which is compounded by the fact that the perpetrator is commonly someone known to and trusted by the child and family. This particularly applies to sibling sexual abuse, which is a hidden and often under-reported form of child sexual abuse. The trauma and emotional distress of being sexually abused by a sibling and the grief associated with having an abusive and abused child or children in the family can have long-term impacts on family relationships. A family's response to a disclosure of sibling sexual abuse is often affected by the confronting nature of the abuse (Strathopoulos, 2012).

The interpersonal, long-term, repeated and sustained experiences of violence often experienced by victims of childhood sexual abuse create ongoing traumatic legacies that often extend beyond the long-term health and social impacts listed above. In response, the concept of complex PTSD has been developed. In this context, PTSD symptoms were identified as representing only part of the bigger picture surrounding complex PTSD, which includes:

- difficulty controlling emotions
- difficulties with interpersonal relationships, especially isolation and difficulties with trust
- constant feelings of emptiness or hopelessness
- feelings of shame and worthlessness

- feelings of being completely different to other people
- dissociative symptoms
- feeling like no one would ever understand the experiences of sexual abuse that happened
- self-harming behaviours, suicidal ideation and suicide attempts
- somatisation (Mind, 2018).

In her foreword to *Treating Complex Traumatic Stress Disorders* (Courtois & Ford, 2009), Judith Herman says that “[t]he beauty of the complex post-traumatic stress disorder (PTSD) concept is in its integrative nature. Rather than a simple list of symptoms, it is a coherent formulation of the consequences of prolonged and repeated trauma.”

The lack of a single pattern of symptoms to characterise the consequences of childhood sexual abuse has led some researchers to develop models to better understand the processes of entrapment of victims and their ongoing psychological, emotional and relational turmoil.

One such model was developed by Browne and Finkelhor (1986) as the Four Traumagenic Dynamics Model. This model suggested four dynamics arising from child sexual abuse:

1. traumatic sexualisation (where sexuality, sexual feelings and attitudes develop inappropriately)
2. a sense of betrayal (because of harm caused by someone the child vitally depended upon)
3. powerlessness (because the child's will is constantly contravened)
4. stigmatisation (where feelings such as shame or guilt are constantly reinforced and become part of the child's self-image).

While these four dynamics are not unique to only child sexual abuse, it is argued that it is the combination of these dynamics that makes this type of trauma unique. The individual dynamics may vary in the ways they operated for each victim, and this both explains the variation in symptoms and also suggests that interventions need to address each specific dynamic appropriately rather than take a general, rigid approach to every individual victim.

Laing (1987 & 2018) extended thinking about the dynamics and what she termed the legacies of child sexual assault, exploring four key areas that included:

1. **The dynamic of responsibility:** where the perpetrator denies responsibility for the abuse and gives the child that message that the abuse is the child's fault. As a consequence, the child is left with a legacy of **guilt and self-blame**.
2. **The dynamic of secrecy:** to ensure that the sexual abuse can continue, the perpetrator must separate the child from those who may protect them, isolating the child from support and a belief they cannot tell someone what is happening to them. The legacies for the child are **isolation and ongoing doubt about their own reality**.
3. **The dynamic of protection/loyalty:** the child holds the protection of others, including the perpetrator, as their responsibility. They do not hold any sense of entitlement for themselves but what they have to give others, leading to legacies of **self-erasure and super-responsibility for others**.



4. **The dynamic of power (revised to resistance):** the child's relationship with the perpetrator is characterised by his use of power over tactics, which discount their experience and create a climate of fear and intimidation. The legacy of the child is one of **fear, a sense of violation and powerlessness**. Laing subsequently revised this to replace the power/powerlessness duality with power/resistance (see, for e.g., Laing, 2018). In this shift, she acknowledges the writings of practitioners in the area of response-based practice who argue that whenever people experience oppression, including the oppression of sexual violence, they will always resist (Todd & Wade, 2004).

Such explanations dramatically shifted the view of the victim's experience from an individual perspective only, creating a new understanding of how their identity, their relationships and ongoing struggles were created by legacies of the violence. It created an awareness of the critical role played by the tactics of abuse in creating not only a falsely constructed identity for the victim and a falsely constructed reality of their life, but also a falsely constructed connection to others.

Laing's work in particular connected perpetrator tactics and legacies to the broader socio-political context that supports the too common occurrence of child sexual abuse, including:

- patterned gender inequalities (patriarchy, abuse of power)
- the position of children in society (invisible, innocent, misunderstanding experiences)
- secrecy (silence through fear, disbelief, coercion)
- responsibility (deny, minimise, excuse, blame others such as mothers)
- protection/loyalty (sanctity of family, community, institutions).

### Making resistance visible

Research reminds us that children, young people and adults are not passive recipients of the violence to which they have been subjected. Rather, they find ways of dealing with what is happening to them while maintaining some sense of separation from the violence and therefore some connection, be it small or even invisible at the time, to who they are and remain despite what has happened or is happening to them.

Resistance is eloquently described by Wade (1997) and when we hold that lens when responding to victims of sexual abuse there will always be evidence of their resistance to the abuse they were subjected to. Wade proposes that:

any mental or behavioural act through which a person attempts to expose, withstand, repel, stop, prevent, abstain from, strive against, impede, refuse to comply with, or oppose any form of violence or oppression (including any type of disrespect), or the conditions that make such acts possible, may be understood as a form of resistance ... Further any attempt to imagine or establish a life based on respect and equality, on behalf of oneself or others, including any effort to redress the harm caused by violence or other forms of oppression, represents a de facto form of resistance. (Wade, 1997, at p. 25.)

A person's resistance does not and cannot stop violence but this does not mean it lacks significance, especially with regard to upholding their dignity and self-respect. Empowering children, young people and adults and acknowledging their 'actions' of resistance in the context of violence is essential to their wellbeing.



## Responsibility versus vulnerability

Sexual assault is a crime for which the victim has no responsibility. People often confuse vulnerability with responsibility in the context of sexual assault. There are factors that make people vulnerable to sexual assault such as gender, age, sex, disability, being affected by alcohol or drugs, mental health issues, previous child sexual assault and experiences of other forms of childhood adversity, location, housing and social disadvantage. It is important to remember, however, that sexual assault happens when the perpetrator exploits these **vulnerabilities** and that does not make the victim **responsible** for the assault (Yarrow Place, 2009).

Perpetrators of sexual assault and their supporters often use a range of strategies such as emphasising the victim's vulnerabilities or their actions (e.g. what they were wearing, previous sexual activity), to minimise the nature, extent or impact of their violence and invalidate the experiences and credibility of their victims (Costello, 2009). Such strategies seek to shift responsibility from the perpetrator to the victim by blurring the boundaries between vulnerability and responsibility. In the case of child sexual abuse, perpetrators often also seem to place responsibility not only on the victim but also on non-offending family members, significant others and carers.

It is therefore important when working with clients, service providers and communities to both hold perpetrators and the systems and circumstances that allow them to perpetrate sexual assault responsible for the sexual assault and to unpack this confusion and complex relationship between vulnerability and responsibility.

## Other perpetrator tactics

Perpetrators' strategies, behaviours, and decisions to offend are shaped by the interpersonal, situational and social contexts in which they occur — their strategies are context-dependent (Clark & Quadara, 2010). Although their strategies, behaviours and decisions are shaped by context, it is widely acknowledged that perpetrators make deliberate choices.

It is recognised that grooming can occur with both adults and children, and is 'the process by which a person prepares a victim for, and strengthens, a pattern of sexual abuse'. It includes two stages: (1) non-sexual and (2) sexual (Tidmarsh, Powell, & Darwinkel, 2012).

In the first stage, the perpetrator grooms the victim and surrounding environment to establish power and control. In the second stage, the perpetrator begins to sexualise the relationship, often by beginning with non-threatening touches (e.g. hugging, tickling) before moving to sexual acts. The stages may occur consecutively or concurrently, and may progress over varying periods of time (Tidmarsh et al., 2012). Often a perpetrators' strategies will: isolate the victim/survivor; control the situation; and impose their own desires, intentions and perspectives on the interaction (Clark & Quadara, 2010).

For child sexual abuse in particular, it is commonly perpetrated by someone known to the child and family. Perpetrators of child sexual abuse exploit trust, authority and power over the child, may make them feel special through gifts or bribes, make them feel complicit in the offending and use threats, force and tricks. Offending behaviour is often characterised by denial and attempts to establish allies who will support this denial. When considering tactics used against children and young people, the perpetrator may use some or a combination of the following:

- deliberately targeting a vulnerable child
- deliberately targeting very young children
- building trust with a child and/or the child's family
- separating a child from family and/or friends
- establishing power and control over a child
- treating a child as 'special'
- using a child's natural need for touch and affection
- confusing a child
- desensitising a child
- creating the idea that the abuse is the child's idea or fault
- encouraging secrets
- making sure the abusive touching is pleasurable for the child (CASAC Inc., no date).

### **Gendered nature of sexual assault**

Sexual assault is a gendered abuse of power and an act of humiliation and control. Perpetrators force, coerce, harass and/or pressure someone into sexual activity to which they do not or cannot consent. As the statistics above show, sexual assault is gendered in that the majority of victims are female. In addition, the vast majority of perpetrators are male, and gendered differences in victimisation experience exist (e.g. women are more likely than men to be assaulted by a partner, girls are more likely to be assaulted in family and community contexts and boys are more likely to be assaulted in institutions) (Costello and Backhouse, 2019a).

The gendered nature of sexual assault does, however, extend beyond these statistics of victimisation and perpetration in two main interrelated ways. First, a sexual assault is not a one-off incident but occurs in a broader context of gendered and other power relations at individual, community, system and societal levels, as illustrated in the socio-ecological model of violence against women reproduced in the graphic below from [\*Change the story: A shared framework for the primary prevention of violence against women and their children in Australia\*](#) (Our Watch, VicHealth & ANROWS, 2015).

**Figure 20: socio-ecological model of violence against women**  
(reproduced from Our Watch, VicHealth & ANROWS, 2015)

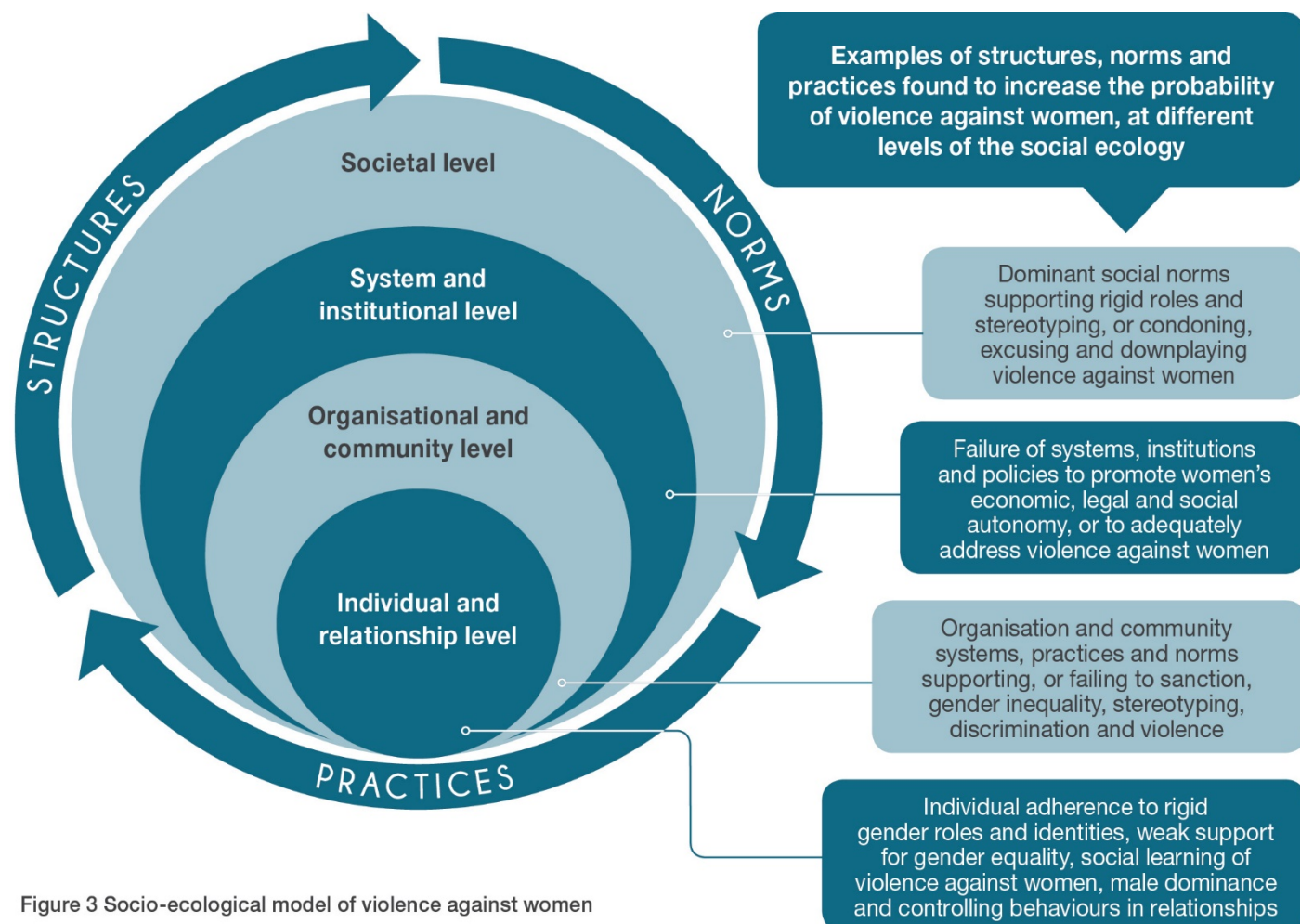


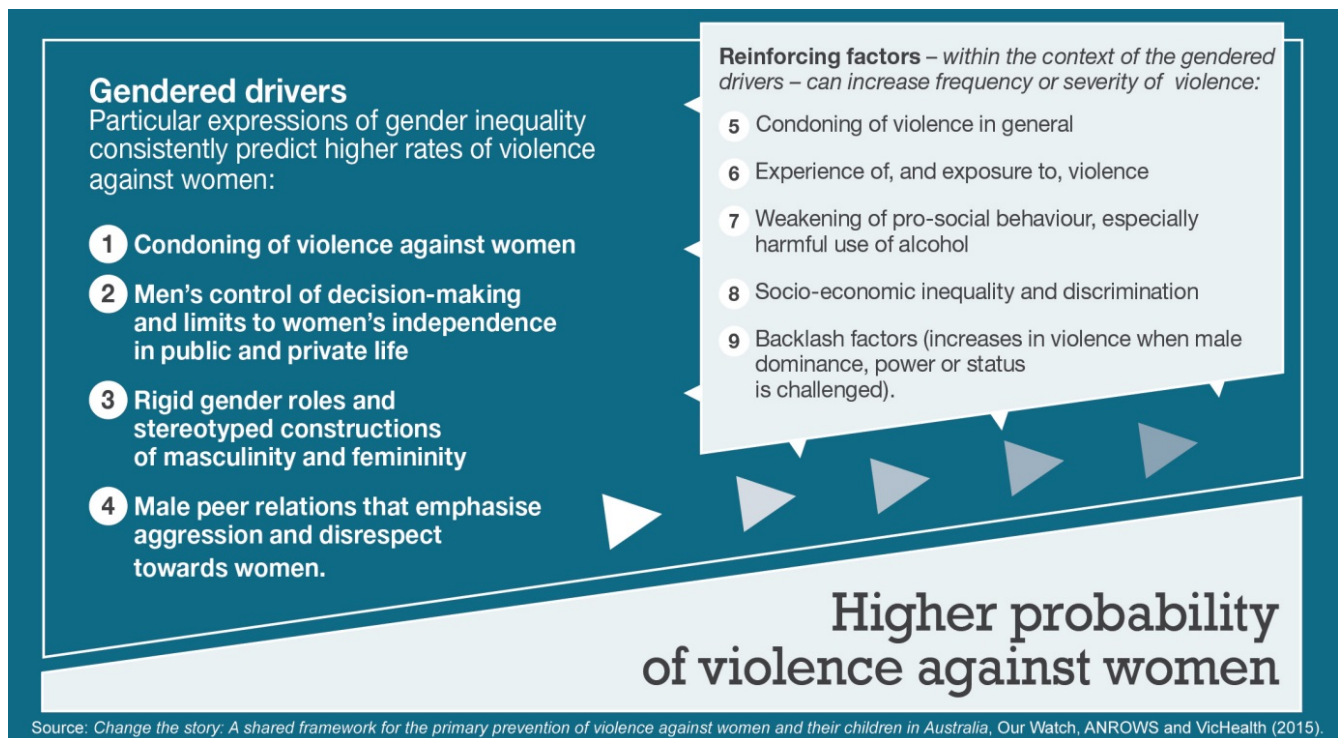
Figure 3 Socio-ecological model of violence against women

Source: *Change the story: A shared framework for the primary prevention of violence against women and their children in Australia*, Our Watch, ANROWS and VicHealth (2015).

Significantly, these gendered power relations affect the relationship between both men and women and men and other men, since men are also subjected to stereotypes and dominating social expectations around traditional models of masculinity (NASASV, 2015).

*Change the story* (Our Watch, VicHealth & ANROWS, 2015) provides an explanatory model of violence (see graphic below) which is based on this socio-ecological model and a strong evidence base identifying gender inequality as the fundamental social context underpinning violence against women, including sexual assault. This model identifies the gendered drivers of violence alongside the reinforcing factors that increase the probability of violence occurring.

**Figure 21: Gendered drivers and reinforcing factors of violence against women**  
(reproduced from Our Watch, VicHealth & ANROWS, 2015)



Importantly, gender inequality does not operate in isolation and intersects with other forms of social, political and economic discrimination and disadvantage to make some women (e.g. Aboriginal women or women with a disability) and non-dominant men (e.g. men who don't conform to rigid constructions of masculinity) particularly vulnerable to sexual assault (Our Watch, VicHealth & ANROWS, 2015; Costello, 2009).

Second, sexual assault is gendered in that it is not only underpinned by gender inequality but also acts to express and reinforce gendered power relations. It does this by being a masculinising act for the perpetrator and a feminising act for the victim regardless of the actual gender of the perpetrator or victim (Atmore, 1999; Gillespie, 1996).

Placing responsibility on the perpetrator and making visible the complex social conditions that perpetuate sexual assault, while important, continues to be a challenge, particularly when social attitudes and social policy trends favour the individualisation of social problems.

## Barriers to disclosure

There are many barriers to disclosing sexual assault that prevent many people who have been assaulted from seeking help to overcome the effects of the assault or report it to the police. These may include

- it is often perpetrated by those closest to the victim (e.g. family members and partners)

- social stigma and victim blaming attitudes
- a lack of understanding among the public of the extent and nature of sexual assault
- societal misconceptions and myths about sexual assault, resulting in victims and their non-offending family/significant others/carers experiencing guilt and shame
- fear for their safety or the safety of others
- fear of the consequences, especially if they are a child
- having a relationship with the perpetrator
- belief that nothing will come of disclosure.

Children and young people face additional barriers in disclosing the abuse such as:

- the abuser may be the child/young person's primary carer
- the child or young person is trapped into an ongoing abuse process, with the perpetrator using tactics of control and manipulation to ensure the abuse is not disclosed
- children/young people who have been groomed or who have limited experience, understanding or cognitive ability may not understand what constitutes sexual assault
- the child or young person may feel they are to blame for the abuse, particularly when they were groomed and coerced to 'participate' in sexual acts
- fear of retaliation from the perpetrator
- the expectation adults may have about how children disclose abuse, which may not be consistent with how children actually disclose (e.g. adults may expect children to explicitly state that they were abused)
- not having someone to trust to disclose abuse to
- mainstream health workers, education, legal and other professionals are often poorly informed about children's disclosures, including misconceptions regarding memory, recanting, showing vs telling, displays of affection for a perpetrator, forensic evidence, and so on, which can result in minimising disclosure, misinterpreting, and non-reporting.



## APPENDIX 2: LEGISLATIVE AND POLICY CONTEXT

Legislation and policies of particular relevance to these policy and procedures.

### Legislation

- [Children and Young Persons \(Care and Protection\) Act 1998](#): Chapter 14 includes a range of offences involving children and young persons. Chapter 16A concerns the exchange of information about a child or young person and coordination of services. Section 245C of the Act allows a prescribed body to provide information of their own accord to another prescribed body that relates to the safety, welfare or wellbeing of a particular unborn child, child, young person or 'class of children' or young persons.
- [Children \(Criminal Proceedings\) Act 1987](#): This act contains the age of criminal responsibility.
- [Child Protection \(Working with Children\) Act 2012](#): stipulates that only people with valid Working with Children Checks are engaged in child related work (where a child is under the age of 18 years) — refer to the NSW Health Policy on [Working with Children Checks](#).
- [Crimes Act 1900](#): Part 3 of the Act lists 'Offences against the person', which includes a range of potentially relevant crimes related to violence, abuse and neglect involving children. This includes homicide (Division 1), acts causing danger to life or bodily harm (Division 6), assault (Division 8), assaults etc. at schools (Division 8B), rape and sexual assault (Division 10), kidnapping and child abduction (Division 14), child prostitution (Division 15), and child abuse material (Division 15A).
- [Crimes \(Domestic and Personal Violence\) Act 2007](#): Part 3 defines domestic violence and other offences. Chapter 13A enables the exchange of information in accordance with the related protocol to facilitate access to domestic violence support services for people at serious threat.
- [Crimes Act 1914 \(Cth\)](#)
- [Evidence Act 1995](#): Part 3.10 deals with the privileges that may impact on the admissibility of evidence, one of which (Division 1B) is for confidential communications made about sexual assault.
- [Family Law Act 1975 \(Cth\)](#): The act states that when a court is considering a child's best interests, the court is to give greater weight to protecting children from the risk of violence, which is a primary principle (along with the right of children to have a meaningful relationship with both their parents). This means that children must be protected from the direct harm of violence and the harm that results when they are exposed to family violence against other family members. This includes sexual assault or other sexually abusive behaviour.
- [Guardianship Act](#)
- [Health Practitioner Regulation National Law 2009](#): Division 1 of Part 8 of the National Law defines 'unsatisfactory professional conduct' and 'professional misconduct', which are notifiable under the *Health Services Act 1997*. Division 2 of Part 8 of the National Law outlines mandatory notification requirements for registered health practitioners in relation to notifiable conduct.
- [Health Records and Information Privacy Act 2002 \(HRIP Act\)](#)



- [Health Services Act 1997](#): This outlines how health services are established, funded and operate in NSW. Part 3 of Chapter 8 of the Act outlines mandatory reporting requirements regarding certain conduct by visiting practitioners. Part 2 of Chapter 9 of the Act outlines mandatory reporting requirements regarding certain conduct by staff of the NSW Health Service. Section 10 of Chapter 2 of the Act outlines the scope of functions of districts.
- [Mental Health Act 2007](#)
- [Ombudsman Act 1974](#): This prescribes the responsibilities of heads of agencies for preventing, and for responding to, allegations, charges or convictions of a child protection nature against staff (where a child is defined as being under 18 years). This extends to allegations relating to conduct that has occurred outside of work or prior to the staff member's engagement, including historic matters where the alleged victim may now be an adult. Refer to the NSW Health policy on [Child Related Allegations, Charges or Convictions against NSW Health staff](#).
- [Victims Rights and Support Act 2013](#): This requires that any person or agency exercising official functions in the administration of the affairs of the state must (to the extent that it is relevant and practical to do so) consider the [NSW Charter of Victims Rights](#) (see further below) in their interaction with a victim of crime.

## Policies

- [Child Related Allegations, Charges and Convictions Against NSW Health Staff](#): This sets out the mandatory requirements for managing child-related allegations, charges or convictions against anyone working in NSW Health, where the alleged victim was under 18 years of age at the time of the alleged conduct. This extends to child pornography, non-work related and historical matters.
- The [Child Wellbeing and Child Protection – NSW Interagency Guidelines](#) provide information and guidance to organisations involved in the delivery of child wellbeing and child protection services in NSW.
- The [Child Wellbeing and Child Protection Policies and Procedures for NSW Health \(NSW Health PD2013\\_007\)](#) outlines mandatory reporting and other legal responsibilities of Health services and Health workers to promote the health, safety, welfare and wellbeing of children and young people.
- The [Domestic Violence – Identifying and Responding](#) outlines the characteristics and consequences of domestic violence and identifies the role of NSW Health generally and Area Health Services (now called Local Health Districts) specifically, in recognising and responding to domestic violence. The policy provides direction on the routine screening for domestic violence program in services where significant numbers of women have been found to be at risk.
- [Identifying and responding to abuse of older people](#) describes how to identify and respond to abuse of older people and outlines the responsibilities of NSW Health Organisations to implement local protocols. It identifies and briefly outlines the intersection between abuse of the older people, domestic violence and sexual assault.
- The [Integrated Prevention and Response to Violence, Abuse and Neglect Framework](#) provides a strategic platform for all of NSW Health to respond to violence, abuse and neglect alongside detailed guidance for NSW Health's specialist Violence, Abuse and Neglect

services. It emphasises the need to mobilise NSW Health at the system, service and practice levels to support integrated service responses to victims and families.

- [Managing Complaints and Concerns About Clinicians](#) provides a standard approach for the management of serious complaints and concerns about clinicians working in NSW Health.
- [Managing Misconduct](#) sets out the requirements for managing potential and/or substantiated misconduct by staff of the NSW Health Service and by visiting practitioners.
- The [NSW Health Privacy Manual for Health Information](#) provides operational guidance for health service staff to the legislative obligations imposed by the *Health Records and Information Privacy Act 2002*. The document outlines procedures to support compliance with the Act in any activity that involves personal health information.
- *NSW Police, Health, and Office of the Director of Public Prosecutions Guidelines for responding to adult victims of sexual assault* (NSW Police, NSW Health & ODPP, 2006) are designed to improve the services to adult victims of sexual assault by promoting increased interagency cooperation and provide procedural and operational matters related to adult sexual assault within each agency.
- [Photo and video imaging in cases of suspected child sexual abuse, physical abuse and neglect](#) provides statewide direction for on the required standards for capturing, storing and managing clinical imaging for people 0-17 years old. The policy outlines procedures to support compliance with consent, privacy, and documentation management and retention policies.
- [Sexual Safety — Responsibilities and Minimum Requirements for Mental Health Services](#) provides direction to mental health services regarding the establishment and maintenance of the sexual safety of mental health consumers who use their service.
- [The Sexual Safety of Mental Health Consumer Guidelines](#) (NSW Health GL2013\_012): provide details for mental health services staff about the processes for reporting sexual safety incidents to Police. Section 4: Interagency context.
- [Subpoenas](#) outlines legislative provisions and procedures to be followed when the Ministry of Health and public health organisations are required to produce documents on subpoena. It includes advice on Sexual Assault Communications Privilege as the grounds for challenging a subpoena.
- [Your Health Rights and Responsibilities NSW Health](#) outlines how the seven basic rights summarised in the *Australian Charter of Healthcare Rights* are achieved in New South Wales.
- [National Framework for Protecting Australia's Children 2009-2020](#) is an ambitious, long-term approach to ensuring the safety and wellbeing of Australia's children and aims to deliver a substantial and sustained reduction in levels of child abuse and neglect over time. It includes high level and other supporting outcomes and actions which are being delivered through a series of three-year action plans.
- [National Plan to Reduce Violence against Women and their Children 2010-2022](#) brings together the efforts of the Australian state, territory and Commonwealth governments to make a real and sustained reduction in the levels of violence against women. It has six key outcomes and is being implemented through four three-year action plans.
- [National Risk Assessment Principles for Domestic and Family Violence](#) provide an overarching conceptual understanding of risk and managing risk in the area of domestic and

family violence with the intention of keeping women and children safe. They form an evidence-based risk assessment and risk management framework that can underpin multi-agency or integrated service system responses to domestic and family violence.

## Charters and Conventions

- The [Australian Charter of Healthcare](#) includes seven basic rights of healthcare provision: access, safety, respect, communication, participation, privacy, and the right to comment.
- The [NSW Charter of Victims Rights](#) aims to protect and promote the rights of people who are victims of crime. The charter provides the guiding principles on how victims of crime are to be treated by government agencies: with respect, courtesy and compassion at all times, and by having their needs as victims recognised and met during service delivery.
- The [NSW Code of Practice for the Charter of Victims Rights](#) stipulates responsibilities for NSW Health SASs in providing support and written material to non-offending family members/significant others and carers.
- The [United Nations Convention on the Rights of The Child](#), was ratified by Australia in 1990. The convention is the international instrument that incorporates the full range of human rights: civil, cultural, economic, political and social rights. The convention recognises that people under 18 years old often need special care and protection, by virtue of the fact that they are not adults.
- [United Nations Declaration on the Elimination of Violence against Women](#) was the first international instrument explicitly addressing violence against women, providing a framework for national and international action. It defines violence against women as any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life.
- [World Health Assembly Resolution WHA49.25: Prevention of violence: a public health priority](#) is a resolution adopted by the World Health Assembly 1996 declaring violence a major and growing public health problem across the world. It calls for the introduction and implementation of specific policies and programs of public health and social services to prevent violence in society and mitigate its effect.

## APPENDIX 3: STANDARDS FOR CHILD SAFE ORGANISATIONS

### Standards for Child Safe Organisations

The [Royal Commission into Institutional Responses to Child Sexual Abuse](#) identified 10 Child Safe Standards, which are incorporated in, and underpin, the [National Statement of Principles for Child Safe Organisations](#) that have been endorsed by the Coalition of Australian Governments. The standards identified by the Royal Commission are designed to be ‘high level’ and flexible enough to support localised implementation and recognise a range of organisational types, sizes and capacities. The standards aim to drive implementation of child-safe cultures for all sectors and within all organisations providing services to children and young people.

For SASs, client safety is core business, and it is important to remember when implementing the standards that new policies and practices are to avoid creating undue burden on the organisation and workers, which may divert resources away from serving children and young people. The standards do not prescribe additional activities for SASs, but provide a systematic framework to guide ways of working that prioritise children and young people’s safety, wellbeing and participation.

In many ways, the standards reflect various aspects of the SASs framework for effective practice, including, for example, an emphasis on privileging children/young people’s participation and agency through authentic collaboration between counsellors, children/young people and their families; the importance of child-focused complaints processes; and of culturally safe and inclusive service-provision to all children/young people irrespective of their abilities, sex, gender, migration status, or social, economic and cultural background. Ensuring that SASs are child-safe organisations is particularly important in preventing additional systems-generated harm to vulnerable children, young people and their families.

A range of resources and practice guidance are available to support SAS staff and management to implement the principles, including but not limited to:

- [Child protection training for all NSW Health employees](#)
- [NSW Health Code of Conduct](#) and [Child Related Allegations, Charges and Convictions against NSW Health Staff](#)
- [The Aboriginal Child Placement Principle](#) (see also [Section 21](#))
- [Children and Adolescents — Guidelines for Care in Acute Care Settings](#)

- The NSW Office of the Children's Guardian [Child Safe Organisations program](#) of training and resources

It is expected that all NSW Health organisations, including SASs, implement the Child Safe Standards.

## **Implementing the Standards**

The Standards for Child Safe Organisations ([Section 3.3](#)) provide a systemic framework for organisations to address the cultural, operational and environmental risks that could increase the likelihood of abuse of children, or which inhibit detection of, and appropriate and proportionate responses to, harm to children within organisational contexts.

The standards are not intended to be followed uncritically or inflexibly by NSW Health staff. Instead, the standards are principle-based and focused on outcomes and changing institutional culture. They are designed to be flexible enough to support local implementation across diverse service settings, while still providing clear guidance on how organisations need to strike a balance between caution and caring. Policies must avoid creating undue burden on services, which may divert resources away from serving children, young people and families. For these reasons, responsibility for meeting the standards must be shared across all levels of the organisation, including SASs clinical leads and Local Health District divisional managers.

SASs are to consider each standard, identify related risks, and develop ways to manage or mitigate those risks. The safety and wellbeing of children and young people is core business for SASs. The implementation guidance and practical examples provided in the table below aim to reflect and build on existing effective approaches to organisational safety within SASs and to support local, context-specific implementation of the standards.

Importantly, children and young people are a key client group of SASs. For example, children and young people may access services as victims of sexual assault, as under 10 years old and seeking support to address problematic sexual behaviours, or because they are in the lives of other adult and child clients. It is therefore essential to ensure that the service environment and all practices are child-safe.

Child Safe Standard	Implementation guidance and practice examples
<b>1. Child safety and wellbeing is embedded in organisational leadership, governance and culture</b>	<p>A child-safe organisation is one that demonstrates active commitment to children and young people's safety and wellbeing, at all levels of the organisation. Achieving Standard 1 means that the organisation's leadership and management promote an inclusive, welcoming and accountable environment and culture for children and young people. Governance arrangements are to be transparent and include a child safety and wellbeing policy, practice guidance, a code of conduct and a risk management framework. Organisational leadership provides an authorising environment for the sharing of information about risks to children and young people.</p> <p>For example:</p> <ul style="list-style-type: none"><li>• SAS executive, management and clinical leads demonstrate through their actions and behaviours that SAS core business is to empower children and young people and support their safety when accessing the service, either as a direct client or family member.</li><li>• The service makes its commitment to child safety explicit, for example through a public statement on its website or through visible and accessible informational posters and flyers (for example, see this hospital <a href="#">poster designed by children</a>).</li><li>• The risks to child safety in activities planned for in and outside the service are assessed and addressed as part of ongoing risk management strategies, and explicit provisions are made for children's safety in outreach activities (<a href="#">Section 13.2.2</a>).</li><li>• In collaboration with clients and their families, services sensitively consider and plan for any risks to safety that may be associated with children with harmful sexual behaviours accessing the service alongside victims of sexual assault.</li><li>• SAS counsellors provide important specialist advice and training to workers outside the service (<a href="#">Section 19</a>). Practice tools such as supervision meeting agendas or phone advice scripts aim to build capacity and encourage reflection on organisational safety in other services.</li></ul>



<b>2. Children participate in decisions affecting them and are taken seriously</b>	<p>Standard 2 describes an organisational culture that supports children and young people to understand what child safety and wellbeing means. Children and young people are informed about their rights and responsibilities in an age appropriate way. They contribute and actively participate in building a safe organisational culture.</p> <p>For example:</p> <ul style="list-style-type: none"><li>• Children and young people access resources that explain their rights and responsibilities when they are accessing the SAS either as a direct client or family member.</li><li>• One of the approaches underpinning SASs, client-centred practice, indicates that children are the experts in their own experiences and are often best placed to guide decisions around how to manage their own safety (<a href="#">see Appendix 4</a>). Services are proactive in empowering children and young people to participate in decisions about therapeutic responses.</li><li>• Children are involved in service improvement activities including monitoring and review.</li></ul>
<b>3. Families and communities are informed and involved</b>	<p>Standard 3 emphasises the importance of involving families, carers and community members in an organisation's approach to child safety, including in the development and implementation of relevant policies, practices, and informational resources. This will help inform parents and carers about organisational safeguards, and encourage their feedback and input. Organisations are inseparable from their communities and both need to work together to enhance the safety of children. Due to their primary responsibility in the upbringing of children, parents, carers and families are often best placed to advise about their children's needs, capabilities and protective networks.</p> <p>For example:</p>

	<ul style="list-style-type: none"> <li>• Services engage local communities in collaborative ways to prevent child abuse from occurring. This includes being responsive to diverse needs, including building cultural safety<sup>47</sup> through local partnerships and respectful relationships (<a href="#">Section 21</a>).</li> <li>• SASs work collaboratively with parents and families, ensuring a trauma-informed, family and person-centred response. Interventions that improve outcomes for parents and carers improve the safety and wellbeing of children.</li> <li>• SASs seek input and feedback from families and communities and provide clear and accessible information about child safety and wellbeing policies, code of conduct, record-keeping practices and complaints and investigation processes.</li> <li>• Resources are available and accessible for families and diverse community members that clearly explain their rights and responsibilities.</li> <li>• Materials are visible, available and accessible for families and diverse community members that clearly explain their rights and responsibilities (for example, see the Sydney Children's Hospitals Network <a href="#">Rights and Responsibilities for Families</a> brochures and posters).</li> </ul>
<b>4. Equity is upheld, and diverse needs are taken in to account</b>	<p>Standard 4 considers how recognition of children and young people's diverse circumstances enable an organisation to work in a more child-centred way and empowers children and young people to participate more effectively. This builds an organisational culture that acknowledges the strengths and individual characteristics of children, and embraces all children regardless of their abilities, sex, gender, or social, economic and cultural background. A welcoming organisation is one where all children and young people feel comfortable and where services are provided in culturally safe and inclusive ways. This reduces the risk of discrimination, exclusion, bullying and abuse.</p> <p>For example:</p>

<sup>47</sup> The term 'cultural safety' describes an environment 'where there is no assault, challenge or denial of [a person's] identity, of who they are and what they need' and refers specifically to Aboriginal and Torres Strait Islander peoples (Williams, 1999, p. 213). This encompasses Aboriginal and Torres Strait Islander individuals' assessment of their safety and capacity to engage meaningfully, on their own terms and with a non-Indigenous person or institution. This requires action from the non-Indigenous person or institution to listen, enable and support these environments, with accountability to Aboriginal and Torres Strait Islander colleagues of service users (Walker, Schultz, & Sonn, 2014).

	<ul style="list-style-type: none"> <li>Addressing organisational cultural safety through implementation of audit and collaboration tools such as the <a href="#">SNAICC Partnership Audit Tool</a>, which supports genuine interagency and community partnerships in service delivery for Aboriginal and Torres Strait Islander children and families.</li> <li>Ensuring SASs' therapeutic responses for Aboriginal women, children and families actively consult, record and follow the guidance of those children and families, using the <i>Template to Record Aboriginal Cultural Consultation</i> (<a href="#">Section 21.4</a> and <a href="#">Appendix 10</a>).</li> <li>SASs recognise that culture is protective against harm to children and are guided by the expertise and demonstrated resilience of Aboriginal children and communities on how best to support their ongoing safety, including through trauma and racism-informed practice (see section 21). One way that SASs could do this is by supporting staff to understand the core elements and aims of the <a href="#">Aboriginal Child Placement Principle</a>.</li> <li>Setting up or joining collaborative practice with other services in the local area that have particular expertise in supporting children and families with more specialist or complex needs, such as disability advocacy or settlement services.</li> </ul>
<p><b>5. People working with children are suitable and supported</b></p>	<p>Standard 5 describes recruitment and staff development policies, including appropriate screening, that are a foundation of child-safe organisations. This standard also includes induction training, understanding child safety responsibilities and cultural safety concepts, and appropriate supervision of staff and volunteers. Reporting obligations, training in record keeping, and information-sharing provide staff and volunteers with the relevant practice tools to better safeguard children and young people.</p> <p>For example:</p> <ul style="list-style-type: none"> <li>As well as conducting Working with Children Checks, services undertake screening and recruitment processes such as values-based interviewing (e.g. 'how do you relate to children?') and asking referees specifically about suitability to work with children.</li> <li>Staff are made aware in an ongoing way of reporting obligations and child safety responsibilities, including through induction processes and policies, and know who to ask for help and support to meet reporting and other safety responsibilities.</li> </ul>

	<ul style="list-style-type: none"> <li>Adequate supervision is provided to SAS clinical staff, including access to cultural supervision (Sections <a href="#">21</a> &amp; <a href="#">23.6.6</a>). Regular and formalised supervision is critical to mitigating risks of vicarious trauma and to ensuring effective child-safe practices, and draws on resources including the NSW Health Education and Training Institute's (HETI) <a href="#">Superguide: A handbook for supervising allied health professionals</a>, and the <a href="#">NSW Health Clinical Supervision Framework</a>.</li> </ul>
<b>6. Processes to respond to complaints of child sexual abuse are child-focused</b>	<p>Standard 6 provides guidance on how human resource management policies and practices and effective complaints management processes should be accessible, responsive to and understood by children and young people, families, staff and volunteers. Complaint management processes will be linked to the code of conduct and provide details about where breaches of the code have occurred. Training will help staff and volunteers to recognise and respond to neglect, grooming and other forms of harm, provide appropriate support to children and young people in these instances and meet legal requirements. This includes training to assist in responding to different types of complaints, privacy considerations, listening skills, disclosures of harm and reporting obligations.</p> <p>For example:</p> <ul style="list-style-type: none"> <li>Recognising that child-focused complaint processes don't just happen and are an essential component of child-safe organisations. The service actively seeks children and young people's participation. Children and families are involved in the design of the complaint-handling processes (<a href="#">Section 23.5</a>).</li> <li>Staff have confidential ways to raise concerns, including about another staff member, where appropriate.</li> <li>All complaints are taken seriously and are acted on appropriately and proportionately.</li> <li>Relevant policy directives are followed, including the <a href="#">Child Wellbeing and Child Protection Policies and Procedures for NSW Health</a>; <a href="#">Managing Misconduct</a>; <a href="#">Child Related Allegations, Charges and Convictions against NSW Health Staff</a>, and the <a href="#">NSW Health Policy on Managing Complaints and Concerns about Clinicians</a>.</li> </ul>

<b>7. Staff are equipped with the knowledge, skills and awareness to keep children safe through continual education and training</b>	<p>Standard 7 emphasises the importance of information, ongoing education and training for staff and volunteers. Staff and volunteers build on their knowledge and skills and evidence-based practice tools through professional seminars and memberships, supervised peer discussions, team training days and access to research and publications. This ensures staff and volunteers develop awareness and insights into their attitudes towards children and young people, and have a contemporary understanding of child development, safety and wellbeing. They will be able to identify indicators of child harm, respond effectively to children and young people and their families and support their colleagues. Staff and volunteers are able to respond in culturally appropriate ways to children and young people who disclose or show signs that they are experiencing harm outside the organisation.</p> <p>For example:</p> <ul style="list-style-type: none"><li>• Managers and clinical leads encourage staff engagement with relevant policy directives and clinical guidelines, including these clinical guidelines. These resources provide evidence-based research synthesised to be useful for effective practice and are intended to build capacity and be educative, not simply procedural in nature.</li><li>• Staff are supported to access formal training and education opportunities — for example NSW Health <a href="#">ECAV</a>, as well as the extensive training available to NSW Health Staff through NSW Health Education and Training (HETI).</li><li>• All staff complete the <a href="#">HETI Child Wellbeing and Child Protection training</a>.</li><li>• Staff are supported to access targeted resources to improve practice, including, for example, the <a href="#">suite of 'child safe' resources</a> developed by the NSW Office of the Children's Guardian.</li></ul>
<b>8. Physical and online environments minimise the opportunity for abuse to occur</b>	<p>Standard 8 highlights that reducing the risk of harm in physical and online environments is an important preventative mechanism. Risk management strategies clarify potential risks where adult-to-child or child-to-child interactions occur, or where the physical environment is unsafe. Technological platforms within organisations provide valuable tools in education, communication and help-seeking. Risks associated with these platforms are minimised through all necessary</p>

	<p>means, including: education of children and young people, parents, staff and volunteers about expectations of online behaviour; the application of safety filters; and communication protocols.</p> <p>For example:</p> <ul style="list-style-type: none"> <li>• Precautions are taken so that an adult is not alone with a child unobserved, through, for example, ensuring clear line of sight (doors are open) when children and young people are receiving therapeutic treatment alone.</li> <li>• Services have clear social media policies that address contact with clients online, and draw on resources such as those produced by the <a href="#">Office of the e-Safety Commissioner</a>, including the <a href="#">Young &amp; e-Safe</a> resource.</li> <li>• Children's physical safety and wellbeing including cultural safety is to be taken into account in the design of clinical environments, including both physical and online environments. Children and young people are to be consulted in the design.</li> <li>• SAS outreach services (<a href="#">Section 13.2.2</a>) play a critical role in ensuring equity and accessibility of the service, particularly for people living in rural and remote areas, and for families with specific cultural or confidentiality needs. Local Health Districts have a responsibility to ensure child safety and sexual assault counsellors' safety have been addressed and assessed in accordance with the <a href="#">NSW Health Work Health and Safety: Better Practice Procedures</a> and <a href="#">Protecting People and Property: NSW Health Policy and Standards on Security Risk Management for NSW Health Agencies</a>. This will include case-by-case risk assessment and mitigation processes, and the implementation of safety precautions such as ensuring interpreters, cultural consultants and disability support workers are present as required.</li> </ul>
<p><b>9. Implementation of the Child Safe Standards is continuously reviewed and improved</b></p>	<p>Standard 9 emphasises that child-safe organisations seek to continuously improve their delivery of child-safe services and their operations. They also conduct reviews to ensure that organisational policies and procedures, including record-keeping practices, are being implemented by staff and volunteers. The participation and involvement of staff, volunteers, children and young people, families and community mentors in these reviews will strengthen the organisation's child safeguarding capacities. This includes the importance of reporting on the finding of reviews and</p>



	<p>sharing good practice and learnings on a regular basis. Regular reviews ensure that organisations address new challenges or concerns that arise.</p> <p>For example:</p> <ul style="list-style-type: none"> <li>• Building on SAS clinical staff's existing reflective practices, SAS managers and clinical leads support a practice culture of continuous quality improvement regarding child safety. This might include critical reflection, supervision, and active, ongoing evaluative processes. These practices inform improvements to the service as a whole (<a href="#">Section 23.6.6</a> &amp; <a href="#">Appendix 4</a>).</li> <li>• In all review and improvement activities, children and young people are primary stakeholders and are consulted.</li> <li>• Complaints and 'near misses' lead to a review of practice and corresponding updates to policies and procedures.</li> <li>• Audit tools for monitoring, evaluating and reviewing the implementation of Child Safe Standards are developed or sought, and used regularly, transparently and independently if required.</li> </ul>
<p><b>10. Policies and procedures document how the institution is child-safe.</b></p>	<p>Standard 10 outlines the importance of organisations having a clearly documented child safety and wellbeing policy. This will ensure all stakeholders, including organisational staff, volunteers and children and young people and their families and carers, are aware of how the organisation is planning to meet its obligations to create an environment that is safe for children. Partner agencies or organisations funded to provide services to children and young people are to demonstrate adherence to child safety and wellbeing policies and practices. Importantly, policies and procedures do not stand in place of active child-safe practices and ongoing critical reflection, monitoring and review of those practices.</p> <p>For example:</p> <ul style="list-style-type: none"> <li>• Local policies accurately reflect each service context and the context of the communities it serves, document how the service is child-safe, and do so in easily understood language and format.</li> </ul>

	<ul style="list-style-type: none"><li>• Staff are supported by clinical leads and managers to access, understand and implement the policies, and there are mechanisms for staff to seek clarity and provide feedback generated through their practice experience.</li><li>• Leaders within the SASs and Local Health Districts champion the standards and model compliance.</li><li>• Audits provide evidence of how the SAS is child safe throughout its governance, leadership and culture.</li></ul>
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## **APPENDIX 4: KEY PRACTICE FRAMEWORKS**

### **Trauma-informed, trauma-specific and violence-informed services and practice**

#### **Being trauma-informed**

NSW Health services and workers responding to sexual assault will use a range of evidence-informed theories, frameworks, treatment methods and counselling approaches that are trauma-informed. Violence, abuse and neglect, including sexual assault, are examples of relational and complex trauma that can lead to many varied consequences for the child and family (Herman, 1997). Trauma-informed care, trauma-sensitive practice or a trauma-informed approach is based on an understanding and acknowledgement of trauma theory. The key element of this approach is that the care model aims to provide a safe, supportive environment to clients and staff that reflects available research about the prevalence and effects of trauma exposure, and the best methods for supporting clients exposed to trauma (Wall, Higgins, & Hunter, 2016).

To be considered trauma-informed, an agency would have moved through the following transformative steps: being trauma aware (seek information out about trauma); becoming trauma sensitive (operationalise concepts of trauma within the organisation's work practice), be trauma responsive (respond differently, making changes in behaviour); and ultimately move to becoming trauma-informed (entire culture has shifted to reflect a trauma approach in all work practices and settings) (Wall et al., 2016).

Trauma-informed practice recognises the range of emotional, behavioural and physical indicators that demonstrate someone is overwhelmed and that are best understood as the person's attempt to survive. A trauma-informed service is aware of the possibility of ongoing or re-traumatisation and of the direct and indirect impacts on its staff. It assumes a commensurate responsibility to avoid or reduce these additional consequences wherever possible. Finally, a trauma-informed service recognises the many potential pathways to recovery and to building resilience, of which one may be access to a trauma-specific therapeutic service (Mental Health Coordinating Council, 2013).

Principles derived from trauma-informed practice directly relevant to sexual assault include:

- promoting a safe physical and emotional environment where the client's needs are met and safety measures are in place
- understanding trauma and its multiple impacts includes recognising the adaptive intent behind many of the trauma associated behaviours
- being culturally respectful and informed, particularly in the context of past and present experiences of trauma and healing
- supporting people's control, choice and autonomy, and working towards genuine autonomy and a respect for human rights and freedoms
- dealing directly with issues of power, such as recognising that the greater the power difference, the greater the sense of threat
- the need for precautions to reduce the likelihood of being a further source of trauma

- collaborating with services to provide an integrated and holistic response to support recovery
- promoting safe and genuine relationships
- acknowledging clinicians and other colleagues also need to be safe, supported in the face of vicarious trauma, have a voice and be treated with respect
- recognising the importance of hope, peer support, strength-focused and future orientation

Trauma can impact on families and communities. This is especially evident when working with Aboriginal communities impacted by past government policies of forced removal of children, as well as other consequences of colonisation. It can also be evident in groups that have experienced other community-wide trauma, such as through escaping violence and the process of being a refugee. This highlights the importance of engaging with the whole family and with communities and enlisting the support of cultural consultants, which minimises the potential to repeat past practices of exclusion, discrimination and ignorance exacerbating the trauma experience (Atkinson, 2013).

### **Trauma-specific services**

While ‘trauma-informed services “are informed about, and sensitive to, trauma-related issues”, they do not directly treat trauma or the range of symptoms with which its different manifestations are associated.’ (Kezelman & Stavropoulos, 2012, pp. 86-95). Service responses to sexual assault by NSW Health VAN services will therefore also be trauma-specific. Trauma-specific services are ‘designed to directly treat “the actual sequelae” of trauma experiences and related symptoms and syndromes’ (Kezelman & Stavropoulos, 2012, pp. 86-95).

A trauma-specific service is one that is aware of the possibility of ongoing or re-traumatisation of clients and of the direct and indirect impacts on its staff and takes steps to reduce this. A trauma-specific service recognises there are many potential pathways to recovery and to building resilience in clients. Some features of a trauma-specific service include (Johnson, 2017):

- staff training in the impact of trauma
- use of standardised and evidence-based assessments of trauma history and symptoms
- use of trauma-focused therapeutic interventions
- supporting and developing emotional regulation with families
- actively seeking the participation of the child, family and community in planning and delivering interventions and in providing feedback about what has been achieved
- providing services that are strength-based and promote positive development by building on the strengths, knowledge and lived experience of the individual, family and community
- using written policies that explicitly include and support trauma-informed principles.

Being both trauma-informed and trauma-specific requires services to build on the strengths, knowledge and lived experience of the individual, family and community. This involves actively seeking the participation of the client, family and community in planning and delivering interventions and in providing feedback about what has been achieved.

## **Violence-informed services: contextualising trauma**

It is essential that practitioners working in services responding to violence, abuse and neglect, including sexual assault, use a trauma-informed approach that acknowledges and draw on the following key concepts:

- human rights and social justice
- privilege and power
- gender inequality
- the politics of trauma.

It must be recognised that trauma is a response to violence and abuse such as sexual assault. A trauma-informed framework in the context of violence cannot minimise, rationalise, or pathologise violence and abuse. Both trauma-informed practice and trauma-specific services must move beyond the micro-level of the individual (which can continue to reinforce experiences of disempowerment and oppression, and continue to 'blame' the individual for their responses), to also incorporate the socio-political context in which families live (Quiros & Berger, 2015).

The socio-ecological model ([Section 1.2](#)) is a useful tool to draw on when working in a trauma-informed service. Key concepts from Response-Based Practice (Wade, 2007) also provide an understanding of the impacts of violence and how to work with children, young people, adults who have experienced that violence as well as their families, significant others and carers. Response-based practice is about recognising individuals' inherent ability to respond to adverse situations in the form of resistance. Resistance can take many forms and can often be hidden. Examples may include actions from overtly standing up to a perpetrator through to small acts or thoughts of resistance that go unnoticed by others. Focusing on a victim's responses to adverse situations and working with those strengths is known as response-based practice (Wade, 2007).

## **Collaborative practice and integrated service delivery**

Collaborative practice and integrated service delivery with individuals, families, professionals, including relevant NSW Health and other government services, as well as with non-government organisations, and communities are fundamental to all aspects of the model and service response to both adult and child sexual assault.

Responses to sexual assault necessitate collaboration and integration to be effective. This is due to the complexity and diversity of: the nature of sexual assault; the safety, health, justice, social, and economic needs of people who have experienced sexual assault and their families and significant others; and the service response across government and non-government health, human services, justice (including law enforcement) and education agencies.


While the value of collaboration between services is evident, the different histories, knowledge bases, and organisational cultures of each sector (such as child protection, domestic and family violence, mental health, and drug and alcohol) present formidable challenges to the development of effective working relationships and the sharing of respective expertise (Laing, Irwin, & Toivonen, 2012). Scott (2005) identified five sources of conflict between services that can interfere with collaboration and partnership building that were present at every level from individual to organisational relationships. These included inter-organisational, intra-organisational, inter-

professional, inter-personal, and intra-psychic, and problems in one level could lead to conflict at another level.

No single service or service system has the capacity or expertise to respond to the needs of every client, many clients engage with a range of services during their lifetime, and for many people navigating the service system can itself be traumatic (Royal Commission, 2017, Vol. 9). Evidence of the negative consequences of fragmentation, disconnection and 'siloed' service delivery and the benefits of collaboration means that collaborative practice and integration are widely regarded as best practice in responding to violence, abuse and neglect, including sexual assault, despite some limitations (Breckenridge, Rees, Valentine & Murray, 2015; Royal Commission, 2017, Vol. 9). While being difficult, a collaborative, interagency approach is therefore critical in responding to sexual assault, particularly when taking a public health approach.

Formal and informal integration, coordination and collaboration can take many forms, however, which are best represented through Figure 22 below.

**Figure 22: Continuum of integrated service delivery**  
(Wilcox 2010, reproduced from Breckenridge, et al., 2015, p. 10)



Service autonomy	Collaborative practice	Streamlined referrals	Cooperation	Coordination	Integration
With networking	Formalised networking arrangements and organisational policy development	Incident-based processes, such as police faxbacks	Regular communication around clients and some common goals	Agreed plans and protocols or a separately appointed coordinator	Single system with sub-units and cross-unit accountability

Source: Wilcox (2010, p. 1020).

Regardless of the level of integration along this continuum, key features of successful partnerships between agencies identified from the evidence are:

- 'communication — both formal and informal [including effective handover]
- trust — at each level including between sectors and agencies
- shared goals — transparency of agreed intervention goals
- shared language
- equity between agencies — the role of each agency is equally valued
- leadership — some literature suggests a lead agency is helpful, but all acknowledge that management of client need is important' (Breckenridge et al., 2015, p. 12).

The [Child Wellbeing and Child Protection — NSW Interagency Guidelines](#) offer collaborative strategies to promote access to services and better integration of service delivery which, although applying specifically to children, can also be instructive in our work with adults too. The interagency guidelines emphasise the importance of:

- **building and contributing to better local networks** that foster an understanding of the local agencies



- **agreeing on better ways to work together to support shared clients**, which may involve joint case planning, case conferencing, or cross-agency referrals. These processes help services to consider information about a child/young person or family from their respective professional disciplines, and to consider the best mix of supports.
- **establishing partnerships** to develop integrated responses and address service delivery gaps
- **establishing formal protocols** to ensure that the roles and responsibilities of all services in supporting children, young people and families are clear, such as through memoranda of understanding or protocols
- **creating opportunities for shared training**, which provides a strong foundation for interagency practice. This would improve understanding of services' roles and responsibilities, as well as promoting a shared language, knowledge and awareness between agencies.
- **recognising the function of strengthening relationships** between services, such as within position descriptions and other ways of articulating shared expectations.

## Strengths-based practice

Critical to effective work with children, young people, adults, and their families and significant others is a focus on strengths, not just vulnerabilities, which requires a thoughtful analysis of both deficits and strengths. Supporting people to 'discover resources' in themselves 'however small' shifts the focus from problem finding to 'solution building' and allows them to participate in finding and creating 'building blocks for change' (Turnell & Edwards, 1999, p. viii).

A strengths-based approach does not mean ignoring risks, behaviour or minimising harm. Rather, it contributes to a partnership that is built on transparency and engages vulnerable families in a process of finding hope. Managing the balance between working with strengths while acknowledging vulnerability requires a constant process of assessing, establishing, monitoring and sustaining safety.

## Critically reflective practice

This process of reflection allows practitioners to optimise their capacity for critical reasoning and limit the likelihood of errors of judgement. It helps with the complex task of making in-the-moment decisions as well as more structured thinking and planning, and is based on an understanding of how the human brain processes information to form judgements. In forming judgements, humans rely on two modes of reasoning: intuitive and analytical. Both have something to offer in the complex process of counselling, and each has its strengths and its limitations (Munro, 2008).

- Intuitive reasoning draws on information stored in the more primitive parts of the brain and is a largely unconscious process. It draws on experience — the patterns, emotions, meanings and images rooted in past experience. Intuitive reasoning is quick and effortless, but because it is based on experience, it is prone to bias.
- Analytic reasoning on the other hand, takes place in the neocortex; the sophisticated part of the brain where more complex cognitive processing occurs. It is a more conscious and deliberate process that draws on logic. Because analytic reasoning draws on empirical

information and more formal forms of knowledge it is more reliable, but it requires effort and time.

Munro analysed child death reviews in the United Kingdom and identified the difficulties that occur when intuitive and analytic forms of reasoning are not well integrated. She noted common errors of reasoning that occur in making critical decisions. These included: relying on a narrow range of evidence, overlooking important information that may be known but not necessarily analysed, favouring information that is emotionally arousing and therefore memorable, and failing to revise judgments in the face of new information. (Munro, 2008).

Recognising these common mistakes can lead organisations and systems to systematise processes so that there is less room for 'errors of judgement'. This places more emphasis on formal theory and knowledge and tends to rely on checklists, assessment tools and procedures. However, on its own, this can encourage surface-level thinking and an emphasis on compliance with policy and practice guidelines (Gibbs, 2008). At its worst it can lead to what one author called 'conveyor-belt practice' (Ferguson, 2004). This is characterised by focusing on getting cases through the system, meeting targets, and speedy casework resolution (Chapman & Field, 2007). It does not make best use of the human brain's capacity for complex reasoning.

To avoid this binary between the two modes of thinking, a process of critical reflection is required that uses multiple sources of information and systematically checks intuitive forms of reasoning against objective evidence — that is, a process of reflective practice (Munro, 2008). Reflective practice is a term that is frequently used and there are many models that can be usefully applied. Three important characteristics of reflective practice need to be present in any model:

1. It involves a process of critical reflection that occurs before, during and after practice — **planning** for practice, reflection **on** practice, reflection **in** practice.
2. It uses intuitive as well as analytic forms of knowledge: understanding is derived from integration.
3. It derives learning and new knowledge from experience (Thompson & Pascal, 2012).

Munro (2002) identified five sources of knowledge and skill needed to make effective judgements when working with children, young people and families in the child welfare field. These involve both intuitive and analytic forms of reasoning, and draw on formal knowledge, practice wisdom, emotional wisdom, values and reasoning skills.

**1. Formal knowledge** assists analytic reasoning. It includes laws, policies, procedures, and tools based on empirical research. For NSW Health workers, essential sources would include, but are not limited to:

- violence, abuse and neglect (VAN) policies and procedures and the associated VAN Service Standards
- other relevant legislation and NSW Health policies and procedures
- Local Health District systems and processes
- the *Evidence Check* literature review (Macvean et al., 2015) in relation to interventions for families with complex needs, where children and young people have experienced violence, abuse and neglect

- other literature about the nature of the client group, interventions, etc.

**2. Practice wisdom** is an intuitive form of knowledge that is built on experience in the field and in the social world more generally. It draws on implicitly understood patterns of behaviour, experience of similar situations, the 'mind-reading' skills derived from the social brain (Lieberman, 2007) and 'gut feelings'. Practice wisdom is needed in the moment-to-moment interactions with children and families. It can also inform **how** to do something that formal knowledge would indicate needs to be done by allowing a nuanced and attuned response from the practitioner.

**3. Emotional wisdom** draws on the ability to recognise, process and use emotional information. For example, a SAS counsellor undertaking a home visit may feel afraid. The source of the fear could relate to an actual or perceived threat to safety, picking up on fear felt by one of the family but not directly expressed, or even an activation of the practitioner's own feelings associated with previous trauma. Being able to identify the feeling, process it, manage one's own response and use it to inform the next step all require a high level of emotional capacity. The ability to use emotional information requires the counsellor to be well supported, and for supervision and reflective processes to value the role of emotions in decision-making.

4. **Values** may be explicit, such as those defined in ethical or legislative frameworks, or they may be implicit or even unconscious. Ensuring that values that may be influencing decisions are made explicit means they can be examined and used appropriately. Values that are not explicit or remain unexamined can lead to discriminatory or unethical behaviour.
5. **Reasoning skills** act as the facilitator in the process of integrating analytical and intuitive sources of information. They enable a practitioner to step back and analyse critically the information available, and to balance the different modes of reasoning. This ensures critical decisions are reflective and draw on all relevant information available at any given time. Because humans can never be perfect, and because risk is dynamic and dependent on a range of interacting factors, 'mistakes' can occur. A reflective organisation, supervisor and practitioner will recognise that mistakes occur, will learn from them, and will ensure that these learnings inform future practice.

## Child/young person-centred and family-focused practice

When working with children and young people, it is important to embrace both child/young person-centred and family-focused practice. The discovery of child sexual assault sets in motion a chain of responses that should focus on ensuring the child's safety and ongoing wellbeing. An unintended consequence of this process can be, despite the best of intentions, to further isolate the child or young person from familiar people, most notably their family. Research repeatedly indicates that the most important mitigating factor in reducing the impact of violence is to strengthen relationship between the child and their significant carer (Humphries, 1992; Howe, 2006; Morris, 2011). When responding to child sexual assault, it is therefore essential that any intervention encompass family-focused practice and recognise that the issues and needs of parents and/or carers will impact on the child. Working with the parents and/or carers is therefore integral to improving the safety and wellbeing of the child or young person (Want, 2013).

Child and young person-centred and family-focused approaches are not mutually exclusive. While 'child and young person-centred' refers to placing the needs of the child or young person at the

heart of any decision, being family-focused recognises that the issues and needs of parents will impact on the child/young person (DCJ, n.d.). It is critical that practitioners work with the whole of the family, considering each individual's specific needs in terms of safety and wellbeing in the context of their social environment.

### **Focus on families as a whole**

Evidence-informed interventions with children and young people all have a strong focus on families (Macvean, Sartore, Shlonsky, Albers, & Mildon, 2015). They also recognise that families are a system, not a collection of individuals. Therefore what happens to one family member, including interventions that target one person, inevitably impacts on others. This not only includes the child/young person's immediate family, but their extended family and their caregiving family. As each individual member progresses through their life span, his or her individual development impacts upon, and is influenced by, the development of other family members. Each family therefore has its own life cycle. Each generation deals simultaneously with the challenges of their own development, together with the impacts of the other generations. Events within a generation have an impact on others and thereby shape and influence the development of those around them. A whole-of-family response means understanding the unique developmental challenges the family is facing, individually and as a whole.

Workers need to be mindful that when they intervene with one member of a family, those interventions have consequences for relationships in the family as a whole, not just for the individual who is the focus of intervention. This can be used to target interventions most likely to promote benefit to vulnerable family members.

Drawing on family therapy, anti-oppressive practice, critical reflective practice, strengths-based practice, response-based practice, and the bio-ecological systems perspective, intervention in responding to sexual assault usually involves promoting opportunities for support and positive connection for the child/young person and family unit as a whole, as well as for healing and recovery (where appropriate, such as where the child has also experienced violence, abuse and neglect). This often means working with both parents/carers and the child/young person.

Regardless of whether the child/young person lives with their biological family, the family is always held in mind and issues related to a carer's history are also considered in the context of trauma, attachment and family systems perspectives. Types of work with families can include therapy to help a child/young person develop capacity for self-regulation, to make sense of their trauma experience and to process and integrate the traumatic memories. Other work could include providing psycho-education for the child/young person and their family/carers about sexual assault and the implications of trauma for the child/young person and others.

### **Working in partnership with families**

Building partnerships with families and including their views is fundamentally important and reflects both a family-centred and a trauma-informed response. Parents/carers need to be engaged in goal setting for their children and themselves and in contributing to safety of both their child and other children. As well as ensuring basic values like transparency and respect, collaborative practice means including the family in decision-making (Scott, 2012).

'Parents, play and home environments are critical to child health and wellbeing outcomes. Parenting is so influential that it can moderate the impact of social and economic disadvantage'

(Fox et al., 2015, p. 2). Parents/carers who abuse or neglect their children often face significant challenges that impact on their parenting capacity. Vulnerabilities in families, such as parental experiences of mental illness, substance misuse and domestic and family violence in the home, can contribute to experiences of abuse and neglect for children and young people if the issues are not identified and addressed. A legacy of childhood abuse or trauma they had experienced may also increase the potential for a parent to maltreat their own children (Davies & Ward, 2012, p. 101).

Interventions that improve parent outcomes also improve outcomes for children and young people. Assessments need to identify which issues for parents negatively impact parenting capacity and target interventions to these. Working on improving parental skills and aspects of parenting that are not beneficial for the child/young person will have beneficial outcomes for the child/young person (Davies & Ward, 2012, p. 99). Approaches need to build skills, knowledge and resilience in families as well as to deal with underlying trauma. We also need to learn from the many families that have broken this intergenerational cycle.

Workers need to develop skills and confidence to work with all members of a family, including children, young people and adults. Everyone cannot be a specialist in all areas of practice, but most practitioners can develop adequate skills and knowledge to engage, understand, and build a relationship with all family members. This is particularly important when working with a family where there is domestic and family violence.

The Safe and Together Institute approach to child welfare is predicated on model principles and critical components upon which practitioners from statutory and non-statutory backgrounds can work collaboratively and reach consensus to ensure the safety and wellbeing of children living with domestic and family violence. These foundational elements of Safe and Together aim to enhance the safety of the non-offending parent (usually the mother) by: partnering with her; supporting her protective efforts in keeping the child 'safe and together' with her; and intervening with the offending parent (usually the father) to reduce the risk of harm to the child and to hold him to account for his use of violence and coercive control (Humphreys, Healey & Mandel, 2018).

In meeting with a parent/caregiver conversations may include:

- assisting the family to understand the alleged abuse concerns
- exploring feelings/thoughts/fears regarding their response to the sexual abuse of their child
- providing information to assist the parent/carer to understand how the abuse may have occurred, the reasons for the child's disclosure or inability to disclose and the most appropriate ways to respond at this point in time
- providing or finding an appropriate and private space to the parent/carer as they work through their own reaction to what has occurred including their own trauma issues
- current immediate needs and ways to connect them with practical assistance (food, clothing, accommodation, finances)
- discussing supports and resources (informal and formal) existing or necessary to support this family so as to ensure the needs of both parents and children will be met
- ascertaining the relationship between the child and parent/carer and their emotional availability to take position of support and protection

- discovering other stresses and past experiences that may be impacting on their current handling of the situation with which they have been confronted
- enabling the family to understand the impact of the sexual abuse and how it may be shown by their child, behaviourally, emotionally and physically
- assessing for readiness or hesitancy of the family to engage in ongoing counselling and their ideas as to how what that might involve and how it can be organised
- referring the family to other relevant services and supports.



## **APPENDIX 5: WORKING WITH SPECIFIC POPULATION GROUPS**

The following appendix provides more detailed information on considerations for working with specific population groups in responding to sexual assault. It focuses on those groups whose needs have not already been identified elsewhere in the policy and procedures in terms of providing specific clinical guidance for those groups. This section is best read in conjunction with the statistics on people who are more vulnerable to sexual assault or its effects in [Appendix 1](#). Below is only very general information about the experiences and needs of these groups, and NSW Health workers are also encouraged to attend relevant training and access relevant literature to support their practice with these groups (see, for example, what is available from [ECAV](#)).

### **Lesbian, gay, bisexual, transgender, queer and intersex (LGBTQI) people**

People identifying as LGBTQI or questioning their identity as LGBTQI experience various forms of sexual violence including heterosexist sexual violence (through homophobic or transphobic sexual violence aimed at the individual to send a message of hatred and intolerance), gender based violence, and sexual violence that occurs in same-sex relationships (Fileborn, 2012). Individuals who identify as LGBTQI face additional barriers when reporting sexual violence or seeking support. These include:

- an entrenched myth that sexual violence does not happen in same-sex relationships (Girschick, 2002)
- not wanting to draw negative attention to LGBTQI communities (Duke & Davidson, 2009; Girschick, 2002; Todahl, Linviolle, Bustin, Wheeler & Gau, 2009; Vickers, 1996), particularly as this may fuel homophobic or heterosexist beliefs
- LGBTQI victim/survivors may believe an incident is not serious enough to report (Leonard, Mitchell, Pitts, Patel, & Fox, 2008) or certain experiences do not constitute sexual violence
- LGBTQI victim/survivors may believe they will not be taken seriously, or will otherwise receive an inadequate response by police or other service organisations upon reporting or disclosure (Berman & Robinson, 2010; Leonard et al., 2008; Todahl et al., 2009)
- fear of being 'outed' to friends and family (Leonard et al., 2008), particularly for those living in rural or regional areas
- fear of retaliation/retribution from perpetrators, especially in incidents of heterosexist violence and intimate partner violence
- fear of being met with a homophobic or heterosexist response from service providers (Turell & Herrmann, 2008) and/or not knowing whether service providers will be sensitive to the unique needs of LGBTQI individuals, or whether they will be knowledgeable of LGBTQI relationships and sexual practices (Turell & Herrmann, 2008)
- discrimination, including minimisation of choices about sexuality and gender, denial of human rights, limiting of access to education and employment opportunities, discriminatory laws regarding parental rights, hate crimes and gay panic defence laws
- limited access to appropriate and sensitive services, particularly in isolated areas.

## **Culturally and linguistically diverse (CALD) women, migrants and refugees**

There is an increase in the risk of physical and sexual violence for women from culturally and linguistically diverse, migrant and refugee backgrounds. Many refugee women and children have suffered repeated rape and sexual assault as part of systematic sexual violence in their country of origin as a weapon of war or during their settlement journey. These women may have unique needs that need tailored support and interventions, and referral pathways that include Refugee Health Service, STARTTS and other CALD-specific services.

In addition, risks for women from culturally and linguistically diverse, migrant and refugee backgrounds and barriers to accessing support may include:

- lack of support networks
- socio-economic disadvantage (or relying on family for financial support)
- systemic barriers including language, communication, informed understanding, racism and discrimination, cultural stereotypes (Mitra-Kahn, Newbiggin & Hardefeldt, 2016)
- community pressure and lack of knowledge about rights for victims (Allimant, 2005; Taylor & Putt, 2007)
- being more vulnerable to sexual exploitation and added abuse (Refugee Council, 2009). Some women may be at increased risk of sexual violence from strangers because of 'cultural stereotyping' or participation either forcibly or willingly in prostitution
- not seeing sexual violence within marriage as a 'real' crime, not having the knowledge to recognise sexual violence, or stigma associated with speaking out against abuse
- feeling obliged to stay in the relationships where the sexual abuse is occurring due to religious beliefs, rituals, traditional attitudes and rules or worldviews (Allimant & Ostapiej-Piatkowski, 2011)
- fears about breaches of confidentiality and fear of institutional responses, particularly where they have experienced oppressive or corrupt government institutions, systematic torture and trauma, or displacement from their country of origin
- reluctance to report violence against them because of the threat of deportation (Lay, 2006; Taylor & Putt, 2007)
- cultural 'justifications' (Allimant & Ostapiej-Piatkowski, 2011) or cultural barriers (e.g. risk of honour killings for some refugee and migrant women and arranged marriages).

It is important that interventions not only take into account these issues and barriers, but also connect people with cultural resilience and the wisdom of their beliefs and practices in supporting healing and change.

Note, references to female genital mutilation (or FGM) is not provided in this document as, in NSW, FGM, which is an offence under the NSW [Crimes Act 1900](#), is considered to be physical abuse rather than sexual abuse.

## **People living in rural, regional and remote areas**

People living in rural, regional and remote areas of NSW who have been sexually assaulted face various barriers to disclosure and service provision. Some of the key issues for this group include:

- Limited service provision: opportunities for medical, legal or emotional services are very limited, or even non-existent.
- Their economic situation and geographic isolation may further limit their options to disclose the assault or access services to support them.
- Strong community ties in rural areas mean that a victim is more likely to be acquainted with the perpetrator than in urban settings, often resulting in lower reporting (Ruback and Menard, 2001).
- There is an increased likelihood that the person who has experienced violence has personal relationships or connections with service providers, which may place additional barriers to service access regarding shame and concerns about confidentiality.

NSW Health workers must be mindful of these barriers and the practical issues around geography and access to service provision when working with this vulnerable cohort.

## **Children and young people living in or who have lived in OOHC**

Children and young people in care face a number of difficulties 'arising from the circumstances and inadequate care that led them to being removed from their parents, as well as the aftermath and emotional effects of being separated from their parents and family' (Cashmore, 2014). The impact of early neglect and trauma can cross every area of children's lives, negatively affecting their capacity to learn basic self-regulatory skills, develop a moral sense, manage a formal educational environment and make close, trusting relationships (Furnivall, 2014).

Children and young people in care also face the cumulative risk of placement breakdown, unmet physical and emotional health needs, disrupted attachment, loss of contact with siblings and extended family, and disconnection from culture, all of which can contribute to their experience of trauma. In addition, this vulnerable cohort are at risk of sexual violence and exploitation. The Royal Commission found that of the 257 survivors they spoke with who had been sexually abused in contemporary OOHC, 170 (66.1%), said they were abused in home-based care, and 96 (37.4%) said they were abused in a residential care setting. Some were abused in both types of care placements (Royal Commission, 2017, Vol. 12).

The Royal Commission also found that the evidence provided to them by survivors of child sexual abuse in OOHC was reasonably consistent with current research and found that:

- Boys are more likely than girls to be victimised by non-family perpetrators (extra-familial) and by multiple male abusers.
- Girls are more likely than boys to be sexually abused by family members (intra-familial).
- More female survivors (94, or 81.7%) than male survivors (76, or 53.5%) described being abused in home-based care.
- many female survivors also described abuse by multiple perpetrators.

They also found that children and young people in OOHC were more vulnerable to sexual abuse due to: previous experience of abuse or neglect, loss of connection to family and culture, and lack of understanding of what constitutes abuse. As with other priority populations, barriers to disclosure included:

- not understanding what constitutes abuse
- not having someone to trust to tell about the abuse
- language and literacy barriers
- perpetrator behaviours such as threatening a child that disclosing abuse may result in them being sent away, separating them from their school, friends, siblings and all that is familiar.

### **Adult survivors of child sexual assault**

Several studies have found that people who have been sexually abused as children are two to three times more likely to be sexually re-victimised in adolescence and/or adulthood than people not sexually abused as children (Strathopoulos, 2014). Disclosure of historical sexual assault is commonly an ongoing process that takes place over time, rather than being a single episode. An appropriate response to the disclosure is crucial as this will influence how much a survivor discloses. Being believed and validated are of utmost importance.

Numerous events may prompt disclosure by adult survivors of childhood sexual assault, including:

- attending pre-natal services
- death of the perpetrator
- their children reaching the age of their own sexual assault
- birth of a child
- disclosure by a sibling or disclosure by a person assaulted by the same perpetrator
- perceived lack of control by moving into residential care (e.g. aged care or mental health)
- becoming a carer
- community awareness campaigns or publicity around sexual assault
- workplace or other training around sexual assault
- accessing drug and alcohol or mental health services for symptoms/responses due to childhood trauma.

The Royal Commission (2107) describes the significant and difficult barriers that victim-survivors of childhood sexual abuse face in both disclosing and seeking support. These barriers are multiple and include one or more of the following:

- shame and embarrassment felt by the person abused
- perpetrator behaviour and tactics being used to prevent the abuse being identified and to stop victims from disclosing (this can include use of threats, using the victim's fear of retribution (to them or their family), and more subtle forms of manipulation such as grooming and use of power)

- fear of not being believed
- a sense that they should 'get over it'
- concern that no evidence exists due to the abuse occurring historically
- institutional barriers (such as the violence being widespread and accepted within the institution where it occurred, physical punishment or isolation being used to silence victims).

Adult survivors of child sexual assault who are parents can also have additional impacts including:

- anxiety about parenting behaviours, particularly involving personal care of their children
- increased parenting stress and associated parenting difficulties
- limited trust in others as being safe and trustworthy leading to a pattern of anxious and overprotective parenting
- boundary problems between child and parent, limit setting and communication
- lack of energy for parenting due to ongoing impacts and less emotional involvement with their children
- fear of their children being abused and therefore extensive efforts to protect their children (Allbaugh, O'Dougherty Wright, & Atkins Seltmann, 2014; Cavanaugh et al 2015).

In addition, if the child of an adult survivor experiences sexual abuse, the discovery that their child has been sexually abused can set into overwhelming motion the memories, terror and instinctual behaviours that resulted from their own childhood sexual abuse. They may be left with the realisation that their greatest fear, the sexual harm to their own child, has become a reality.

In caring for the wellbeing of any child who has experienced sexual abuse, it is imperative that accompanying assistance is provided to their parent, and even more so when that parent has also been sexually abused as a child. Banyard, Williams & Siegel (2003) noted that for parents who were sexually abused as children, social supports and self-care were important protective factors related to more positive parenting outcomes. In this context, it is very important to encourage parents to voice their distress and give emotional expression to their thoughts and feelings with appropriate support people.

Adult survivors who are the non-offending parent/carer of a child or young person receiving a service response from a SAS are to be provided support by a different SAS counsellor to the one providing support to their child where possible. The level of support will depend on the particular circumstances and the resources available to the service but there is no doubt that when parents are emotionally supported and enabled to better manage the reality of their child's own abuse that the focus on their wellbeing is central to their child's social, physical and psychological wellbeing.

Resources and information about training on working with adult survivors of sexual abuse are available on [ECAV](#)'s website.

## **Older people**

While there is limited research that specifically focusses on the prevalence of sexual assault amongst older women or the characteristics of such assaults, there is sufficient evidence to support concerns that older women remain at risk of sexual assault, regardless of their age and

situation (Clare, Black Blundell & Clare, 2011). Across Australia, 344 reports of 'alleged or suspected unlawful sexual contact' were made in residential aged care during 2011-2012 (Mann, Horsley, Barrett, & Tinney, 2014).

In one study, sexual assault against women in the 55-87 year age group (mean age of 65) shared many characteristics with assaults against women in the younger age groups (Del Bove et al., 2005, cited in Quadara, 2007) in that they:

- were just as likely to experience severe methods of coercion, such as physical violence and restraint, as women in the two younger groups used in the study
- were just as likely to be assaulted by an acquaintance as by a stranger
- sustained similar injuries to those sustained in younger age groups — including soft tissue damage (e.g. bruises) and lacerations, but sustained slightly higher rates of vaginal injuries than younger women.

There are additional risk factors that need to be considered for older women. The individual risk factors widely accepted include that older women will often be dealing with cognitive impairments, disability, frailty or poor health requiring assistance, and are often dependent on community or institutional care (Horsley, 2014; Mann et al., 2014; Kaspiw et al., 2015). There are also increasing numbers of older women reporting homelessness, which may increase their vulnerability and risk of both experiencing sexual assault and increase barriers to accessing appropriate support.

While there is a lack of evidence for the physical, emotional, and mental impacts of sexual abuse on older women, the World Health Organization (WHO) world report on ageing and health states:

When older people, particularly women, are the victims of violent crime, the consequences are often more severe than for other ageing groups: older women are more likely to have a higher need for medical care, to be admitted into a nursing home and to die as a result of an assault. (WHO, 2015, p. 163)

As well as the physical impacts of sexual assault on older women, the psychosocial impacts are profound and can include: an increase in personal fear; a loss of confidence and sense of safety in home, social or residential care settings; and the consequent potential loss of independence or sense of control over one's life (Mann et al., 2014).

When working with the complexity of assault, SAS workers need to be mindful of the complexity of family relationships, issues of trust, shame, vulnerability, incomprehension, the need to balance fear, risk, safety and autonomy while supporting those who are powerless, invisible and living with cognitive impairment.

## **People experiencing domestic and family violence**

Domestic and family violence (DFV) and sexual assault can often occur in the same incident, and is typically referred to as intimate partner sexual violence (IPSV) (Cox, 2016). IPSV is a uniquely dangerous form of DFV which must be specifically considered in all service responses.

Women experiencing DFV and, as a part of the violence experience IPSV, face additional risks. Survivors who are sexually abused by their partners are at a much higher risk of being killed,



particularly if they are also being physically assaulted. IPSV is a significant indicator of escalating frequency and severity of DFV (Backhouse & Toivonen, 2018).

There are additional barriers faced by this population group when seeking help. More so than other factors, IPSV is under-reported and often not disclosed. Commonly held assumptions that IPSV is less serious than sexual violence perpetrated by a stranger, or that discussing sex and sexual assault within relationships is 'taboo' and should remain private, contributes to the particularly acute shame that many victim-survivors of IPSV experience, who consequently may not seek the help they need and continue to suffer their trauma in isolation (Wall, 2012, in Backhouse & Toivonen, 2018).

IPSV carries with it the same impacts as domestic, family and sexual violence. However, there are also factors that contribute to unique effects that are to be taken into account in the risk assessment of IPSV, including but not limited to:

- difficulty defining the act of sexual assault: women are socialised to see rape as occurring between two strangers and may have difficulty naming a partner whom she loves a "rapist"
- longer-lasting trauma: in part, this is because IPSV survivors can face unique challenges around recognising and naming the sexual violence and increased barriers and reluctance to seek support
- higher levels of physical injury: IPSV victim-survivors often experience repeat abuse, which increases the likelihood of physical injury and trauma, and is associated with, for example, enduring and serious gynaecological conditions (Fredericton Sexual Assault Crisis Centre, n.d., in Backhouse & Toivonen, 2018).

In addition to IPSV, domestic and family violence and sexual assault may also intersect in other ways too. For example, sexual assault or sexual abuse against a child or children may be a tactic of control, punishment or other forms of abuse against an adult female partner in the context of domestic and family violence. In one study, 40-55 per cent of children who experienced sexual abuse were also exposed to domestic violence (Kellogg & Menard, 2003). Sexual abuse of children by men who perpetrate domestic and family violence is also likely to be under-reported as children are often too frightened to disclose (Harne, 2011 cited in Department for Child Protection, 2013). In another, children living with domestic violence were found to be at increased risk of experiencing emotional, physical and sexual abuse, with the rate of co-occurrence of domestic violence and child abuse estimated at between 45-70 per cent (Holt, Buckley & Whelan, 2008).

## **People with substance use and dependence issues**

Sexual assault and alcohol and other drug use have a complex association. For some people who have experienced sexual assault, alcohol and other drugs play a functional role or provide a coping strategy that enables survival (Breckenridge, Salter, & Shaw, 2012). Research with survivors highlight that there are common reasons for using alcohol and other drugs, such as numbing and managing emotions, but also that substances may be used to manage nightmares and sleep patterns (Breckenridge et al., 2012), to keep memories and flashbacks at bay in chronically unsafe or unstable situations (Padgett, Hawkins, Abrams, & Davis, 2006), or to minimise trigger and startle responses. In addition, substance use or dependence may have been used by the perpetrator of sexual assault as a tactic to maintain control or increase vulnerability to assault (e.g. where the perpetrator supplies the substance or forcibly administers it).

Barriers to help-seeking for those using substances may include feelings of shame and stigma and a fear of seeking help. Strategies for individual professionals that can support clients with co-occurring sexual assault and substance use include:

- understanding the relationship between sexual assault and alcohol and other drug use
- being aware that this relationship includes individual, but also relational and social contexts
- providing a safe environment for clients to disclose sexual assault and substance use
- enabling trust, through non-judgemental engagement (Australian Institute of Family Studies 2016; CASA, 2016).

## **Sex workers**

Research in the area of sexual violence and sexual assault on sex workers is limited but emerging. Identifying as a sex worker is, in itself, risky. Sex workers who are open about their work often face issues with their family life (family relationships, custody of children, relationships with intimate partners), shame and stigma, legal issues (due to the illegal nature of some of the work), isolation, and are often targets of verbal, physical and sexual abuse (Quadara, 2008).

Sex workers are not a discrete group separate from the community (they are mothers, university students, peers, patients and citizens) and sexual assault impacts on sex workers in the same way it impacts on other victim/survivors, including issues relating to multiple traumatisation. In addition, they often face heightened barriers to help seeking and disclosing sexual violence (Quadara, 2008). These barriers include:

- their experiences of sexual assault in both their work and private lives are often questioned, ignored or silenced
- being seen as undeserving of support or legal justice because they are sex workers
- they are perceived as being to blame for the violence because of their occupation (a principal barrier to disclosure relates to the reactions and responses they may receive from others when it emerges that they are sex worker)
- a large proportion of sex workers have experienced childhood sexual abuse and so the multiple and compounding effect of that abuse impacts the current situation
- many sex workers are isolated and have a lack of support mechanisms due to the nature of the work (Pyett & Warr, 1999)
- there may be repercussions from the perpetrator if they are a client
- they can be threatened to be 'outed' as a sex worker
- brothel owners are understood to discourage sex workers from reporting sexual assault by a client.

## APPENDIX 6: ROLE DELINEATION FOR SEXUAL ASSAULT SERVICES

The role delineation for Sexual Assault Services is reproduced here from B.20 of the [NSW Health Guide to the Role Delineation of Clinical Services](#) from 2016. As this Guide is frequently updated, this table is provided for information only and districts should consult the most recent version of the Guide to inform their planning and delivery of local clinical services.

B20. SEXUAL ASSAULT SERVICES				Minimum Core Services						
Level	Service Scope	Service Requirements	Workforce	Anaest	Op Suite	COU	ICS	Nuc Med	Radiology	Pathology
NPS	No planned service.									
1	Integrated assessment and management of children, young people and/or adults prior to referral to higher level sexual assault service, so as to preserve forensic evidence and provide psychosocial crisis response.  Identify and respond to child health and wellbeing in accordance with NSW Health PD2013_007 <i>The Child Wellbeing and Child Protection Policies and Procedures for NSW Health</i> .	Formal network with Level 4 and 6 sexual assault services (within LHD/SHN if available), including agreed referral processes, clinical advice and support (may include telehealth).  NSW Health PD2013_007 and the <i>NSW Mandatory Reporter Guide</i> (2013) available to staff.  Referral pathways to relevant Aboriginal programs and services.  Quality and risk management programs in line with current National Safety and Quality Health Service (NSQHS) standards.	Joint Investigation Response Team (JIRT) Senior Health Clinician (SHC) available in business hours.  Aboriginal hospital liaison roles available, preferably both male and female.	-	-	-	-	-	-	-
3	As for Level 1. In addition, provide or access to crisis counselling and ongoing psychosocial response for victim and non-offending family.  Provide specialised integrated psychosocial sexual assault response to child, young person and adult victims and their families.  May provide referral to relevant clinical program that provides a response to children and young people aged 10–17 years who sexually abuse and their families (where available).	As for Level 1. In addition, 24 hour availability of identified area in emergency department or elsewhere in hospital for crisis care, integrated assessment, interview and response.  Access to integrated adult clinical forensic examination.  Access to services for problematic sexualised behaviours in children <10 years of age.	As for Level 1. In addition, medical officer trained in sexual assault response available in business hours.  May have Sexual Assault Nurse Examiner (SANE).  Staff trained in the provision of a specialised integrated psychosocial sexual assault response to child, young person and adult victims and their families.	Minimum Core Services may be off-site.						
4	As for Level 3. In addition, 24 hour integrated crisis counselling, forensic and medical care for children, young people and/or adults.  Advise and accept appropriate referrals from lower level services.  Manage and facilitate health response for JIRT matters.	As for Level 3. In addition, provide network support to lower level services, including clinical advice and professional development support.  Consultation available from other clinical specialties including mental health, surgery, gynaecology, and drug and alcohol services.  Consultation available from paediatric specialties.  For children <18 years, formal network with Level 6 child protection service/unit.  For children <18 years, access to video colposcopy for children available on-site.	As for Level 3. In addition, coordinator/s of sexual assault service for the LHD/SHN.  Forensic examiner, who may be a medical officer or SANE or forensic nurse, available 24 hours (may be on call).  Sexual assault or child protection counsellor, able to respond within 1/24 of initial call/ presentation to health service, available 24 hours (may be on call).	Minimum Core Services may be off-site.						

B20. SEXUAL ASSAULT SERVICES Cont.										
Level	Service Scope	Service Requirements	Workforce	Minimum Core Services						
				Anaes	Op Suite	CCU	ICS	Nuc Med	Radiology	Pathology
6	As for Level 4. In addition, accept referrals from Level 3 and 4 services for specialist and forensic medical assessment. Provide 24 hour integrated crisis intervention service with networked Level 6 child protection service. Provide consultation for other health workers in lower level services. Provide consultation and peer review for forensic examiners in Level 1 to 6 services. Extensive program of community education and professional training.	As for Level 4. In addition, formal network with Level 6 child protection service. For adults, Level 5 gynaecology service on-site. For children <18 years, Level 6 paediatric medicine and Level 6 surgery for children services on-site.	As for Level 4. In addition, forensic physician available 24 hours (may be on call). Specialist medical staff (e.g. surgeon, psychiatrist) available for consultation. Paediatrician available for consultation. Multidisciplinary team response available (e.g. mental health, allied health professionals).	Minimum Core Services may be off-site.						
				-	-	-	-	-	1	4
<b>Further Reading:</b> NSW Health PD2013_007 <i>The Child Wellbeing and Child Protection Policies and Procedures for NSW Health Children and Young Persons (Care and Protection) Act 1998 (NSW)</i> <i>NSW Mandatory Reporter Guide (2013)</i> <i>Child Protection and Wellbeing – Interagency Guidelines</i> <i>NSW Code of Practice for the Charter of Victims Rights (2013)</i> NSQHS Standards										
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NSW HEALTH GUIDE TO THE ROLE DELINEATION OF CLINICAL SERVICES – Section Two Clinical Services, Part B Medicine



## APPENDIX 7: ONGOING THERAPEUTIC INTERVENTIONS

### Evidence-informed practice

Evidence-informed practice (or evidence-based practice, as these are often interchangeable terms) is an inclusive concept that is a client and clinician-directed process, rather than solely an application of research to a presenting problem. Evidence-informed practice relies on the clinician's ability to understand the child/young person and family's situation and safety, as well as the available interventions, and integrate all the elements. Evidence-informed practice enables practice to be more person-centred so that interventions can be tailored to the individual, including their needs, strengths and wishes (Brandt, Diel, Feder, & Lillas, 2012).

Haynes, Devereaux & Guyatt (2002) have conceptualised the elements of evidence-informed practice as an intersection of clinical state and circumstances, client preferences and actions, current best evidence, and clinical expertise (Haynes, Devereaux & Guyatt, 2002, cited in Mullen, Shlonsky, Bledsoe, & Bellamy, 2005). It is clinical expertise and judgement that integrates these different types of information to decide what interventions to use when and with whom.

Evidence-based practice (EBP) requires clinicians to study the research, and consider how to apply this according to their clinical wisdom and experience. The value of EBP is in enhancing the practice of clinicians and services, to the benefit of clients and communities. However it is also imperative that practice is held by a framework that upholds principles of social justice within a human rights framework and considers the following professional ethics and values.

**Figure 23: Ethics and values to inform choice of therapeutic interventions**

Ethics and Values	Meaning
<b>Social justice</b>	Sexual assault is a criminal action which warrants a victim-centred and trauma-informed criminal justice system response that holds the perpetrator to account. Therefore, practice must uphold a social justice perspective and seek protection from harm for all clients.
<b>Feminist gender analysis</b>	Acts of sexual assault are a most blatant abuse of power, and responses must address the power imbalance and gender inequality between those using violence (predominantly men) and those experiencing violence (predominantly women and children).

<b>Socio-political context of sexual violence</b>	Sexual violence is by nature a social, gendered and political experience. Therefore practice must consider the role that our broader society plays in reinforcing beliefs and values that subjugate the rights of women and children, and enforce multiple layers of oppression and disadvantage for people further marginalised by race, ethnicity, sexuality, age, disability and class.
<b>Human rights</b>	Sexual assault is a fundamental violation of basic human rights where people are entitled to live in dignity and freedom from fear and harm. The safety of people who experience such violence and the protection of their rights are the paramount considerations in any response.
<b>Responsibility</b>	Responsibility and accountability for sexual assault rests with the perpetrator but the prevention of such violence is the responsibility of the community and society as a whole.
<b>Human dignity and worth, access, equity and cultural safety</b>	To promote practices that respect the unique worth of any person, irrespective of race, gender, sexual orientation, age religion, national origin, physical disability, or any other preference or personal characteristic, condition or status.
<b>Self-determination and empowerment</b>	To promote practices that encourage clients to build on their strengths and enhance their capacity to exercise their right to self-determination without coercion or judgment.
<b>Professional integrity, advocacy and support</b>	To ensure practice is within a defined professional context and be conducted with dignity, respect and responsibility
<b>Collaboration</b>	Intervention must be based on a coordinated and collaborative response with cooperation between relevant agencies, both within and outside the local community, to effect the best outcome for clients

Therapeutic responses to children, young people and adults have become a concertina of different modalities, processes and techniques. The findings of the



Royal Commission (2017) identified several challenges in the provision of therapeutic interventions:

- The study of trauma arising from sexual abuse is relatively recent and, apart from evidence concerning approaches, there is still scant systematic evaluations of most therapeutic interventions.
- The impact of child sexual abuse as experienced by victims, if viewed as distressing and overwhelming responses to the violence they were subjected to, 'makes sense' and therefore caution needs to be given to labelling people with symptoms or disorders requiring treatment.
- Therapeutic interventions are often enveloped by the diagnosis of PTSD which is recognised as not encompassing the entire range of psychological, physical, emotional and relational struggles confronting victims. 'This may include the person's capacity to form trusting relationships, disrupted attachment, altered self-perception, changes in affect regulation, guilt and shame' (Royal Commission, 2017, p. 174).
- The often primary goal of reducing post traumatic symptoms holds a place of merit in the therapeutic landscape, but may not address the entirety of the needs of a victim of sexual abuse, especially when the legacies of isolation, lack of trust, guilt, shame and powerlessness continue to shadow people's lives.
- The efficacy of different approaches does a tremendous disservice to the individual authenticity of people's lives and therefore must be critically reflected on in terms of their suitability, appropriateness and integrity to understanding each person's unique social context, including individual and family strengths and stressors, their social environment and ongoing risk and safety concerns.

There must also be consideration of the current status regarding 'evidence-based' therapeutic interventions and the current privileged position held by studies that appear to uphold scientifically measured evaluations of effectiveness. The conditions under which research is conducted, (restricted criteria for participants involved in studies, being in current "treatment programs" rather than selecting random participants and reducing eligibility criteria to people who, outside of their experience of trauma, may lead relatively stable and supported lives), can easily skew findings (Kezelman & Stavropoulos, 2012).

Current evidence strongly supports cognitive-behavioural therapy (CBT) which is the most studied therapeutic intervention for both adults and children who have experienced sexual abuse. It is currently considered the most effective therapeutic intervention following a single traumatic event, but it has not yet shown similar positive influence for victims with chronic pervasive trauma, including complex PTSD for adult survivors of childhood sexual abuse or children who have also experienced multiple incidents of prolonged and severe sexual harm by someone who betrayed their trust and dependency on them for care and safety.

In recognising the evidence regarding CBT in responding to children who have been sexually abused, Allnock & Hynes (2011) state, “[i]t would be wrong to conclude that other types of therapy do not work, but the evidence is lacking to prove that they do. The therapeutic alliance between the therapist and the client is held to be key to successful therapy”.

Research into the effectiveness of counselling or therapy has consistently shown that approximately 40 per cent of therapeutic change can be attributed to client’s internal resources and extra therapeutic variables and a further 30 per cent attributed to the therapeutic relationship. A remaining 15 per cent can be ascribed to expectancy and hope factors, and 15 per cent to the therapeutic techniques and models of individual approaches (Lambert, 1992; Hubble, Duncan & Miller, 1999).

In other words, the bulk of client improvement is attributable to factors common to various counselling and psychotherapeutic approaches. Sometimes called ‘nonspecific factors’, these elements are distinct from those attributable to specific methods or approaches. Furthermore, as noted by Allnock & Hynes (2011), the ‘therapeutic relationship’ appears to play a significant role.

As the impact of trauma will be different for each client, counselling methods must be carefully chosen to try and achieve a “best fit” for individual client needs, strengths and hopes for change. This may mean the integration of a number of counselling modalities for many of our clients. As stated by Kezelman & Stavropoulos (2012), ‘Siegel notes the need for therapists to have “a spectrum of interventions” at their disposal “in order to create the most effective and individually sculptured therapeutic experiences”. Rothschild likewise advises clients to check that their prospective therapists have training “in at least three methods”’.

There are several themes in regard to interventions that continue to be argued in the literature, no matter what the therapeutic modalities implemented.

- Best practice with children, young people and adults exposed to sexual violence typically involves adoption of a systems approach to intervention and use of multiple intervention modalities that may include individual, family and group interventions.
- Abuse specific interventions, rather than non-directive therapies, appear to achieve the best results in relieving symptoms and accompanying levels of distress for victims.
- The skills and characteristics of the counsellor are critical to enable safe and trustworthy connection for victims of sexual violence. They need and deserve to be listened to, be taken seriously, to be believed, to be supported, and be validated (Allnock & Hynes, 2011).
- Holistic approaches must seek to address all three levels of processing: cognitive processing, emotional processing and sensorimotor processing (physical and sensory responses, sensations and movement).

- Trauma responses to sexual abuse are a response to the violence that people have been subjected to and therefore make sense. They are not and never should be regarded as a failing or sign of damage in the people who experience these responses. They must be held with respect and understanding, no matter the ongoing cost (for the moment) to people's wellbeing.
- Immediate attention to acute stress responses is critical, using psycho-education. Providing information that informs the victim and their extended family and support network what are common traumatic responses to the sexual violence can help diminish anxiety, increase sense of competence and provide a baseline from which to observe, manage and 'push through' those responses when they arise.

## Therapeutic modalities

The following list of therapeutic modalities (provided in alphabetical order so as not to emphasis any particular one) is not exhaustive nor is it exclusive of other therapeutic interventions. Most do not currently hold the evidence base to elevate their status and legitimacy compared with those that have attained evidence status. For each individual person who has experienced sexual harm, they bring with them other pertinent stories about themselves, people in their lives, their histories, their current struggles and, of course, their strengths and hope for change. It is the primary task of any counsellor to discover these stories and form a partnership with people that acknowledges, validates and affirms what they identify as what they need and how the counsellor may be of use to them.

**Figure 24: Therapeutic modalities**

Name	Description	Prominent practitioners
<b>Aboriginal Healing Frameworks</b>	<p>Aboriginal healing frameworks and associated therapeutic interventions require a holistic view of health and wellbeing, considering the social, emotional, cultural, spiritual and physical wellbeing of individuals, family and whole community. This is in contrast to Western medical systems which have a focus on the individual and are disease focused.</p> <p>Common aims of Aboriginal healing programs include increasing social and cultural identity and self-esteem, cultural knowledge and skills and cultural connectedness. There is a focus on enhancing deep listening skills, self-awareness, spirituality, self-reflection, cultural safety, and helping identify the long-term consequences of trauma across generations.</p> <p>The focus of the programs is not limited to the individual but extends more widely to the family and the community,</p>	<p>Healing Foundation</p> <p>Judy Atkinson</p>

	with community ownership of programs and building of community capacity.	
<b>Acceptance and Commitment therapy (ACT)</b>	<p>This therapy acknowledges that in order to cope with past trauma many people use all their efforts to avoid those internal experiences. ACT identifies that such short term strategies have longer term negative consequences and encourages clients to find an alternative way of managing that turmoil.</p> <p>Acceptance is seen as an alternative to avoidant behaviours and encourages clients to focus on making space for unwanted internal experiences, rather than avoiding of fighting thoughts, feelings, memories, sensations and parts of self. Acceptance doesn't mean liking or wanting difficult internal experiences. It means making room for them or letting them be, in order to focus on living a meaningful life. Mindful acceptance is a middle ground between being overwhelmed by one's inner experience and avoiding/fighting it. It is about proactively using skills to keep distress manageable.</p>	<p>Caroline Burrows Robyn Walser Steven Hayes</p>
<b>Cognitive Processing Therapy</b>	<p>CPT was developed as a clinical intervention specific for rape victims with PTSD. It is an exposure and cognitive behavioural therapy (CBT) based application designed to reduce PTSD symptoms and to challenge unhelpful thoughts that can prevent recovery from traumatic experiences. It consists of 12 sessions that can be classed according to four core phases: psycho-education, cautious titrated exposure, CBT techniques and closure.</p>	<p>Patricia Resick</p>
<b>Dialectical Behaviour Therapy (DBT)</b>	<p>Dialectical behaviour therapy is based on cognitive behaviour therapy (CBT), but has been adapted to meet the particular needs of people who experience emotions very intensely. The 'dialectics' means trying to balance seemingly contradictory positions, moving to acceptance of harmful behaviours as being there for a reason and then moving to change those behaviours.</p> <p>The goal of DBT is to help people manage difficult emotions by letting themselves experience, recognise and accept them. From this place of acceptance (making sense of the behaviours) they are then encouraged to regulate those emotions and replace behaviours that are harmful to safer alternative responses.</p> <p>There are typically four skills modules:</p> <ul style="list-style-type: none"> <li>• Distress tolerance: dealing with crises in a more effective way without having to resort to self-harming or other problematic behaviours;</li> </ul>	<p>Marsha Linehan</p>

	<ul style="list-style-type: none"> <li>• Interpersonal effectiveness: how to ask for things and say no to other people, while maintaining self-respect and important relationships;</li> <li>• Emotion regulation: a set of skills to understand, be more aware and have more control over emotions;</li> <li>• Mindfulness: a set of skills to focus attention and live one's life rather than being distracted by worries about the past or the future.</li> </ul>	
<b>Eye Movement Desensitisation and Reprocessing (EMDR)</b>	EMDR aims to facilitate entry into an accelerated an learning state in which trauma experiences can be processed effectively. It uses a phase-oriented approach using a protocol with standardised procedural steps and avoids the need for sustained arousal, detailed description of the event, or prolonged focus on the trauma.	Francine Shapiro
<b>Group work</b>	<p>Research shows that social support can help to buffer some of the stress that sexual trauma can cause, particularly secrecy, isolation and disconnection from others. Group programs provide remedies against these legacies across all ages, and can provide, in a structured and safe way, the support people require but is enhanced by the realisation that others have had similar experiences and therefore they are not alone.</p> <p>Studies report group therapy to be beneficial for the psychological wellbeing of adult survivors (de Jong &amp; Gorey, 1996; Morrison &amp; Treliving, 2006) and survivors themselves report that group settings which enable members to share traumatic material and provide safety, cohesion and empathy are helpful in the recovery process. In Australia, Davidson (2007) conducted an evaluation report of a group program for adult survivors, The Jacaranda Project. As Davidson goes on to note, since her research report, there have been many published studies assessing the effectiveness of group therapy for child sexual abuse survivors, although also noted that there were very few which included outcomes for male survivors.</p> <p>Group work for children and young people has not received the depth of analysis as group programs for adults but practitioners in the field who use group programs as part of overall service delivery testify to their valuable contribution to therapeutic interventions.</p>	<p>Jane Davidson Discoveries (Dympna House)</p> <p>Jacaranda Project (Northern Sydney SAS)</p> <p>Adventures in Groupwork (Rosie's Place)</p>
<b>Narrative therapy</b>	Narrative therapy is a postmodern approach that seeks to be non-blaming and places clients as the experts of their own lives and of the stories they tell. According to this approach, our lives are multi-storied and consist of	David Epston David Denborough

	<p>different experiences that occur over time to form a main theme. Some stories take precedence over others and individuals begin to connect experiences to derive meaning and thus form a dominant story. People who have experienced sexual abuse may hold a dominant story that is aligned with the legacies of the abuse such as self-blame, shame, guilt, and worthlessness. Narrative therapy allows clients to retell or restructure their stories (known as alternate stories) in meaningful ways in order to help reconstruct their identity. This approach views the problem as separate from the person and seeks to find individual competencies, values, and skills that can help in changing the person's relationship with the problem in their life.</p>	<p>Alice Morgan Michael White</p>
<b>Neurobiology of trauma</b>	<p>This is not a specific therapeutic technique or intervention but rather a theoretical understanding of how the brain develops during childhood and how physiological changes in response to stress can interact with a child's neurodevelopment.</p> <p>Neuroscience has also helped move attachment theory to a focus on self-regulation theory in neurodevelopment and a significant symptom being impaired self-regulatory capacities. It is also recognised that the early brain is capable of rebuilding itself and therefore recommendations for therapeutic intervention focus on atonement and attachment processes between children and carers and building problem solving and self-regulation skills.</p>	<p>Bruce Perry Dan Siegel Alan Schore</p>
<b>Play therapy/creative therapy</b>	<p>Using play and creativity as a therapeutic approach, which allows children to express painful feelings through the use of different mediums, including drawings, puppets, sand play, drama and music.</p>	<p>Eliana Gil Cathy Malchiodi Andrew Hill</p>
<b>Response-based practice</b>	<p>RBP considers the social context in which violence has occurred and positions the person as an autonomously acting agent who actively responds to and resists violence, instead of being an object that is affected or acted upon.</p> <p>Two underpinnings of RBP are:</p> <ul style="list-style-type: none"> <li>• Whenever people are oppressed they will always resist</li> <li>• Language and social responses are powerful tools in shaping outcomes for victims and perpetrators</li> </ul> <p>When violence is not properly acknowledged, redressed and safety restored, the suffering of the victim is perpetrated and enhanced.</p>	<p>Alan Wade Linda Coates Cathy Richardson Angel Yuen</p>



	<p>When people receive negative social responses they are less likely to disclose violence again, less likely to cooperate with authorities and more likely to receive a diagnosis of a mental disorder.</p> <p>When they receive positive social responses they tend to recover more quickly and fully, are more likely to work with authorities and are more likely to report violence in the future.</p> <p>RBP identifies four dominant discourses concerning interpersonal violence (including sexual abuse) and the purpose of the work is challenging those discourses and revealing the extent of the violence, clarifying responsibility, shifting alliances to the victim, and revealing resistance.</p>	
<b>Somatic/sensorimotor therapies</b>	<p>Somatic/sensorimotor therapy recognises that traumatic memories are often stored as emotional or physiological memories without associated language. The therapy focus holds that movement is a medium for creating change in a person's physical, emotional and states.</p> <p>Somatic therapies aim to relieve trauma symptoms by focusing on the client's perceived body sensations (or somatic experiences).</p> <p>When traumatic memories are revived, attention is paid to any physical responses that accompany these memories. Physical techniques such as deep breathing, relaxation exercises and meditation are used to relieve these symptoms.</p> <p>Additional physically based techniques are also employed such as dance, exercise, yoga, massage and vocal work.</p>	<p>Janina Fisher Peter Levine Pat Ogden Babette Rothschild</p>
<b>Trauma-Focused Cognitive Behavioural Therapy (TF-CBT)</b>	<p>The treatment addresses distorted or upsetting beliefs and attributions related to the sexual abuse and aims to build the therapeutic relationship while providing psycho-education, skills development, and a safe environment in which to address and process traumatic memories.</p> <p>TF-CBT also helps parents who were not abusive to cope effectively with their own emotional distress and develop skills that support their children.</p> <p>Joint parent-child sessions are designed to assist parents and children to practice and use the skills they have learned and for the child to share his/her trauma narrative while also fostering more effective parent-child communication about the abuse and related issues.</p>	<p>Esther Deblinger Melissa Runyon</p>

## APPENDIX 8: UNDERSTANDING VIOLENCE AGAINST ABORIGINAL PEOPLE

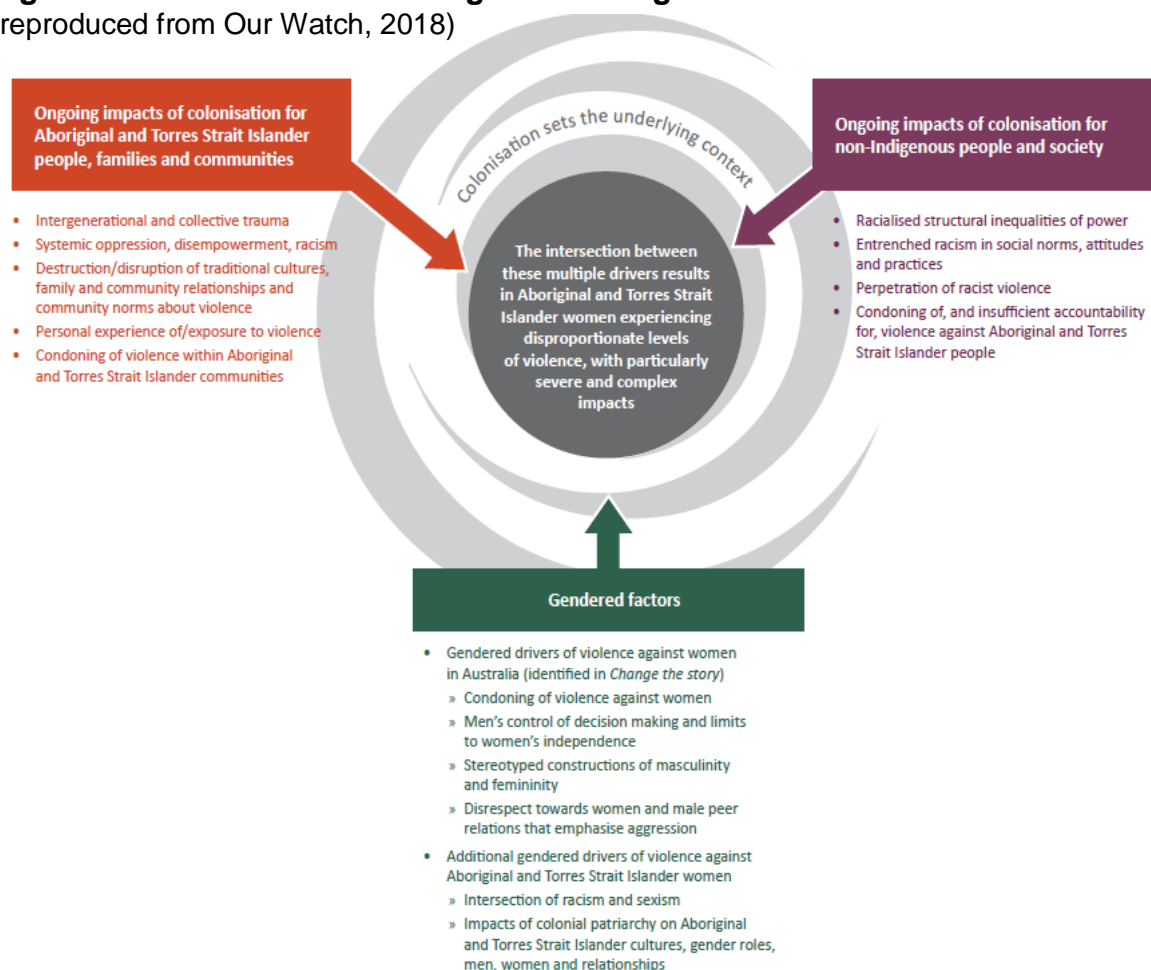
The following is only intended to be a very brief summary and is to be supplemented with appropriate training and the practices outlined in [Section 21](#).

### Understanding the context of violence against Aboriginal people

Healing for many Aboriginal survivors of sexual assault must take account of the historical context and impacts of colonisation. Previous inquiries have documented how this context included violent conflict that destroyed large portions of the Aboriginal and Torres Strait Islander populations, followed by the implementation of discriminatory laws and policies that led to the Stolen Generations.

SAS staff need to understand the drivers of violence against Aboriginal people, and challenge current myths around this violence. Figure 27 from [Changing the picture: A national resource to support the prevention of violence against Aboriginal and Torres Strait Islander women and their children](#) (Our Watch, 2018), highlights these drivers for violence against women, which are also applicable more broadly.

**Figure 25: Drivers of violence against Aboriginal women**  
(reproduced from Our Watch, 2018)



## **Barriers**

Barriers for Aboriginal people in reporting or seeking help for sexual assault may include:

- family and community pressure concerning speaking out about the sexual assault, including a culture of blame being shifted to victims
- feelings of guilt and shame as well as privacy concerns associated with not wanting issues publicly aired. This is particularly critical for those living in small or rural/regional communities.
- fear of retaliation from the perpetrator, their family or community
- fear of being isolated or disowned from family or community if sexual assault is reported, and potentially the loss of connectedness and belonging to family, community, culture and country
- the perpetrator having a position of power within a community, therefore a distrust that authorities will believe them if reported (especially in small communities)
- fear and distrust of the justice system and other government agencies, including a fear of re-victimisation through legal processes
- issues associated with police, including: lack of permanent police presence in some communities; past inappropriate police responses; lack of Aboriginal or female police officers; as well as fear of police attention in light of other matters such as outstanding arrest warrants
- cultural and linguistic communication barriers, including limited English-language skills and a lack of available interpreters
- systemic barriers such as a lack of appropriate services (Australian Law Reform Commission, 2010; Willis, 2011).

## **APPENDIX 9: ABORIGINAL ACTION PLAN TEMPLATE**

### **Sexual Assault Service Aboriginal action plan template**

Sexual Assault Service:

Year:

Date to be reviewed:

<b>Cultural competency</b>	<b>Community engagement</b>
Goal:	Goal:
Aims:	Aims:
Steps to be taken:	Steps to be taken:
Outcomes:	Outcomes:
Coordinator:	Coordinator:
<b>Aboriginal consultation</b>	<b>Supporting the Aboriginal workforce</b>
Goal:	Goal:
Aims:	Aims:
Steps to be taken:	Steps to be taken:
Outcomes:	Outcomes:
Coordinator:	Coordinator:

## **APPENDIX 10: TEMPLATE TO RECORD ABORIGINAL CULTURAL CONSULTATION**

**Sexual Assault Service (SAS) consultation meeting template** *(to record  
consultations)*

Client name:

Date and time of consultation:

Location/method:

Aboriginal consultant (if appropriate to identify)<sup>48</sup>:

Possible conflicts of interest:

SAS counsellor:

Summary of family history/client experience provided to Aboriginal Consultant prior  
to consultation? Yes / No

Questions for Aboriginal Consultant:

1.

2.

3.

4.

5.

Responses/advice regarding questions:

Other recommendations

Sign

Sign

Aboriginal Consultant

Counsellor

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<sup>48</sup> Note — may need to de-identify this form if necessary for the safety and security of the Aboriginal consultant.

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## **APPENDIX 11: ABORIGINAL CONSULTATION COVER SHEET**

### **Aboriginal consultation cover sheet**

*(to be placed on or near front cover of client file)*

Client name:

SAS counsellor name:

Date client commenced work with SAS:

Client informed of availability of cultural consultation at first meeting? Yes / No

Initial consultation between SAS counsellor and Aboriginal worker completed? Yes / No

Client's wishes for cultural consultation documented during assessment phase and a plan made to achieve these? Yes / No

1st consultation completed (assessment phase)? Yes / No

2nd consultation completed (intensive phase/six-month review)? Yes /No

3rd consultation completed (closure phase) Yes / No

Incidental consultations completed:



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