Advocacy Standards for Working with Children, Young People and Adults who have experienced Sexual Violence

These Advocacy Standards aim to provide an outline of core Performance and Knowledge requirements for Australian Government and non-Government agency staff who have an advocacy role in their work with victim/survivors (historical and recent) of sexual violence. This advocacy role might be embedded within another role or be a primary role.

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Parkerville Children and Youth Care
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The project aimed to contribute to the second objective of the FaHCSIA Child Aware Approaches grants ‘to improve or enhance the service response for children and young people experiencing, exposed to or at risk of exposure to domestic/family violence, mental illness and sexual abuse, recognising that substance abuse issues may intersect with these risks.’ The Project goals also aligned to the National Framework for Protecting Australia’s Children, Outcome 6 which is: child sexual abuse and exploitation is prevented and survivors receive adequate support.

The Project team is employed by Parkerville Children and Youth Care Inc., a not for profit organisation in Western Australia. Established in 1903, this agency provides services for vulnerable children, young people and families. More information about Parkerville Children and Youth Care and the Project is available at www.parkerville.org.au and parkervillechildadvocacycentre.com.au

This document and associated resources are available at www.advocacyrole.org

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Preface Information

Aims

Relationship to FaHCSIA Child Aware Approaches
The development of these standards is part of an Advocacy Roles, Skills and Training Project aiming to contribute to Outcome 6 of the FaHCSIA Child Aware Approaches funding grants; “child sexual abuse and exploitation is prevented and survivors receive adequate support”.

Adults, young people and children
The standards aim to clarify the advocacy role for work with victim/survivors who are adults as well as young people, children and their non-offender family members.

While Standard 17 refers specifically to work with children, young people and their families, the other standards also relate to this work. As advocacy with children often involves much work with their non-offender parents/caregivers, the term ‘victim/survivor’ can be read to include this work in the context of the other standards.

Application of the Standards
The use of these standards is voluntary. Possible application of these standards may include;

- role specification in job descriptions;
- a basis for training programs and other professional development such as performance management, coaching and supervision;
- reflective practice; and
- assisting the development of service specifications, workforce planning and quality assurance programs.

Individual role verses organisational standards
These standards are designed to specify the advocacy role rather than organisational or agency standards to support advocacy functions. As the advocacy role contains some responsibility for local system’s advocacy (see Standard 18) some references to service planning is included.
For examples of organisational advocacy standards see:

- George Jones Child Advocacy Centre’s Practice Principles and Standards, Western Australian (click here if viewing electronically); and

**Advocacy role for victim/survivors of sexual violence**

**Definition of advocacy**

Schnieder and Lester (2001) identify the key dimensions of advocacy:

“pleading or speaking on behalf of the disadvantaged, vulnerable, voiceless, and at risk; representing another; taking action; promoting change; accessing rights and benefits; serving as a supporter; demonstrating influence and political skills; securing social justice; empowering clients; promoting self-advocacy and independence; showing compassion and empathy; providing a degree of education/training; using a legal basis or framework” (2001, p. 59).

**Why have Advocacy Standards for victim/survivors of sexual violence?**

Those working in a support role for victim/survivors of sexual violence will recognise that a significant part of their role entails providing emotional and practical supports, helping navigate complex systems, and facilitating empowering opportunities for victim/survivors to have their wishes and needs heard as they deal with an assortment of people in authority.

This multi-faceted role is different enough from a purely therapeutic counselling role for Centres Against Sexual Assault (CASA) agencies (Victoria) to employ practitioners with the title, “Advocate-Counsellor”. In the UK, a new advocacy position of Independent Sexual Violence Advisor (ISVA) has arisen and in the USA agencies with the title of Child Advocacy Centers house multidisciplinary teams including Victim Advocates or Child and Family Advocates as distinct from therapeutic counsellors who are also part of the team. The first Child Advocacy Centre in Australia has been operational in Western Australia since 1st March, 2011 (See Appendix 5 for more information about the George Jones Child Advocacy Centre).

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1 The term “Victim/survivors’ refers to children, young people and adults who have experienced sexual violence. This term may be inclusive of non-offender family members, particularly parent/s or caregiver/s. See terminology for more detail and Standard 17 for more on working with children and families.
While the advocacy role is understood in Australia in areas such work with disabilities, mental health and domestic and family violence, these Advocacy Standards aim to specify this role as it applies to those who work with victim/survivors of sexual violence.

Empowerment is a recurrent and central theme common to all advocacy areas. It is the backdrop against which the other standards sit. Empowerment is not included as one of the 19 standards as individually and collectively they all contribute to empowerment. However, in order that this key element is not lost the summary skills document does include empowerment as an advocacy domain (see Appendix 3).

Relationship to other standards, national competencies and agency guidelines

Key sources from which these standards were developed
These Advocacy Standards are based on:

- consultations with victim/survivors of sexual violence;
- consultations with clinical workers providing services for of sexual violence;
- two Literature Reviews undertaken as part of this Project:
  - the advocacy role for child, young people and adult victim/survivors of sexual violence;
  - the advocacy skills required work in this area;
- A range of advocacy and related standards from Australia, the UK and USA.

(See References/bibliography these and other related publications including Internet links to source documents where available.)

Relationship to NASASV Standards and Certificate IV in Community Services Advocacy
These standards should be used in conjunction with agency policies, guidelines, frameworks and state legislation. See Olle (2005), Mapping health sector and interagency protocols on sexual assault for a table of state by state guidelines.

These Standards are designed to complement and build on the National Standards of Practice for Services Against Sexual Violence (NASASV, 1998) which are currently under review, as well as the nationally recognised Certificate IV in Community Services Advocacy (CSC41012).

The complexity of the Advocate role with victim/survivors of sexual violence presumes a minimum level of professional development equivalent or better than Certificate IV in Community Services.
While designed for Australian use nationally, these standards are currently not included in Australian Quality Framework (AQF) for use in nationally accredited vocational training.

**Endorsement**

*Reviewed by Reference Group*

These standards have been reviewed by the Reference Group for the Advocacy Roles, Skills and Training Project (see Appendix 4 for membership).

**Terminology**

| CASA | The Victorian Centres Against Sexual Assault (CASA) Forum is the peak body of the 15 Centres Against Sexual Assault, and the Victorian Sexual Assault Crisis Line (after hours). For more information, see [www.casa.org](http://www.casa.org) |
| CASV | The Centre Against Sexual Violence (CASV) Inc. is a community based sexual assault service for the Queensland Logan, Beenleigh and Beaudesert communities. [www.casv.org.au/](http://www.casv.org.au/) |
| ISVAs | Independent Sexual Violence Advisors (ISVAs) are victim-focused advocates, funded to work with victims of recent and historic serious sexual crimes to enable them to access the services they need in the aftermath of the abuse they have experienced. Source: [www.homeoffice.gov.uk/crime/violence-against-women-girls/sexual-violence/isva/](http://www.homeoffice.gov.uk/crime/violence-against-women-girls/sexual-violence/isva/) |
| SECASA | South East Centre Against Sexual Assault [www.secasa.com.au](http://www.secasa.com.au) |
| Sexual violence | Sexual violence refers to all type of non-consensual contact and non-contact sexual abuse and can be used interchangeably with the terms sexual assault and sexual harm. |
| Victim/Survivor | Victim/survivor [of sexual violence] may include work with family members (refer to Standard 17 for clarification). This term denotes both the disempowering impacts of sexual violence as well as the more empowered state feeling like a survivor. Some people will experience feeling like a survivor immediately after being sexually assaulted while for others, feelings/behaviours more closely associated with being a victim may predominate for life, for most it will be mixed. An additional term ‘Thriver’ has been used in self-help literature. e.g. Whitfield, B. (2003) [www.cbwhit.com/Victim-to-survivor.htm](http://www.cbwhit.com/Victim-to-survivor.htm) Dillmann, S. (2011) [www.goodtherapy.org/blog/victim-survivor-thriver-trauma-stages/](http://www.goodtherapy.org/blog/victim-survivor-thriver-trauma-stages/) |
Performance (P), Knowledge and Understanding (K), Skills

**Performance (P)** elements refer to what the advocate is required to do. Performance needs to be observable and assessable. Embedded in performance are skill sets which have not necessarily been made explicit in these Standards but should be included in any training/performance development associated with these Standards.

**Knowledge and understanding (K)** elements should also be observable and assessable. The terms, ‘describe’, ‘discuss’, ‘list’, ‘identify’ or ‘demonstrate’, etc., can be used interchangeably as appropriate in each element as a competency of knowledge and understanding.

**Skills**

Advocacy skill sets associated with performance elements have not been included in these Standards as Appendix 3. Skill sets tend to be implicit in reference to the performance elements, however, they need to be explicit in any learning/training programs; supervision/coaching and possibly also in quality assurance programs.

Foundation skills relating to communication (verbal and non-verbal), engagement, emotional support, assessment, case formulation and planning, documentation/record keeping and liaison/networking are presumed to be part of minimum, pre-requisite qualifications.

In his book *Advocacy and Social Work Practice*, Wilks (2012), mentions other, more specific advocacy skills including: crisis management; information gathering; negotiation and assertiveness; presenting a case; working with groups; and empowerment. He also identifies other associated sub-set skills which should also be considered in professional development and quality assurance programs.

**Review**

These standards should be reviewed at regular intervals to incorporate practice feedback as well as new trends and research. It is suggested that they are reviewed one year after first publication and at least every two years after that.
The Standards

Standard 1: Deemed to be of ethical character and accountable for actions

Why this standard is important

“If she’s [ISVA²] not here, I can leave a message and then she phones me back as soon as she’s able to really. I’ve never even waited ‘til the next day before she’ll ring… so she always gets back to you the same day.” (Survivor in, Robinson, 2009).

Victim/survivors have had their trust betrayed, often by people they know through the sexual violence. They may have also had negative previous experiences with professionals and those in positions of authority. In addition, victim/survivors may present in vulnerable and fearful states.

Advocates need to be people who victim/survivors can trust (ethical) and count on (follow through and accountable). Advocates who have their interests of victim/survivors at heart, who act on with promises, who are present for them, and who are transparent with their own limitations and failures as well as those of the systems in which they operate will help to rebuild trust.

Performance criteria to meet this standard

P 1.1 Provides an up to date police check and in applicable states, working with children / vulnerable people check.
(For more detail, see www.aifs.gov.au/cfca/pubs/factsheets/a141887/)

P 1.2 Provides two recent character referees – one professional, one character when applying for work in this area.

P 1.3 Upholds values and code of ethics consistent with emotional and physical safety including the importance of victim and child rights, professional standards, empowerment and transparency. (See Appendix 2 for examples of Codes of Ethics suitable for Advocates).

P 1.4 Follows procedures and seeks supervision regarding client and staff safety procedures.

P 1.5 Demonstrates ‘presence’ when with victim/survivors. Is emotionally and physically attentive to the victim/survivor.

² ISVAs - Independent Sexual Violence Advisors – See Terminology page for more detail.
P 1.6  Informs victim/survivor of their availability and offers alternative support options for times and situations when they are not available.

P 1.7  Follows through on tasks and promises with the effective use of task management systems such as a diary and/or Microsoft Outlook and recording in client notes.

P 1.8  Develops and/or utilises review procedures such as supervision, regular feedback to victim/survivors and their families, and multidisciplinary case review meetings to ensure accountability of self, family members and other professionals.

P 1.9  Documents client interactions, case plans and related activities in accordance with agency procedures.

**Knowledge and understanding to meet this standard**

K 1.1  Identifies staff procedures relating to staff and client safety and in particular, procedures to protect staff and clients from allegations of sexual misconduct.

K 1.2  Demonstrates knowledge of a suitable code of ethics as in Appendix 2 of these standards.

K 1.3  Outlines factors such as being present, following through on promises and tasks and transparency of actions which are associated with building trust and accountable practice.

K 1.4  Describes the agency’s recording and reporting procedures.
Standard 2: Advocacy is led by the views and wishes of victim/survivors

Why this standard is important

"The most important principal to remember is effective support requires all workers to ensure a survivor's active choices are made BY the survivor, not FOR the survivor." (South East Centres Against Sexual Assault [SECASA], 2012)

In systems of competing needs such as the community’s need to prosecute the perpetrator, family’s need to take revenge against or protect the perpetrator or the victim, or the child protection worker’s need to act in the best interests of a child, victim/survivors views and wishes may be lost, not be heard or not be well presented.

The advocate’s role is to hear the views and wishes of victim/survivors, provide adequate information to enhance their ability to make informed decisions and if required, to represent these views without bias. This is different from giving advice or guidance.

When victim/survivors have limited ability to express their wishes, advocates use non-instructed advocacy techniques as in Standard P 2.6 and Standard 17 for child informed advocacy.

Performance criteria to meet this standard

P 2.1 The victim/survivor leads the advocacy process including levels of support required. The advocate allows the victim/survivor to choose support/advocacy options from no support, emotional or information support only, assistance in self-advocacy or to fully represent the victim/survivor’s views and wishes on their behalf. Other support options are discussed.

P 2.2 Victim/survivors are provided with a range of timely support and case progression options. Choice of consenting or not consenting to options is made clear along with positive and negative implications associated with decisions.

P 2.3 Victim/survivors are provided with developmentally appropriate, relevant information and supported in helping to interpret this information and make informed decisions. (See Standard 12 on Provision of information).
P 2.4 Identifies possible personal, professional and agency bias in an effort to provide independent, bias free support and representation. Where bias is identified, it is eliminated or minimised where possible, and if it is unavoidable, is made clear to the victim/survivor. (See Standard 4 on Independence).

P 2.5 Provides transparency of service provision such that no service actions or goals are hidden.

P 2.6 Where communication difficulties such as age, mental health, physical disability or developmental delay makes it difficult for the victim/survivor to express their wishes, non-instructed advocacy techniques are used such as;

- non-verbal and other communication techniques to get to know and explore likely wishes and needs of victims;
- views of non-offender family and friends are obtained;
- seeks supervisory support in cases non-instructed advocacy and when victim/survivor wishes are different for what the advocate believes is in their best interest, or the wishes of parent/caregiver(s); and
- questioning of service providers to ensure the above measures have been undertaken.

Knowledge and understanding to meet this standard

K 2.1 Describes the differences between informed decisions, assisting with interpreting of information, giving advice and providing guidance.

K 2.2 Describes the difference between assessments aimed at making judgements about what professionals think should be done and gathering information and views to represent the wishes and needs of victim/survivors.

K 2.3 Outlines a range of reporting options and consequences associated with these options.

K 2.4 Demonstrates knowledge of legal, welfare and health systems associated with victim/survivors of sexual violence advocacy.
K 2.5 Identifies resources and methods for explaining elements of the legal, welfare and health systems associated with victim/survivors of sexual violence including how to offer options at various points.

K 2.6 Explains how decisional frameworks are used to assist victim/survivor decision making.

K 2.7 Describes an understanding of different approaches which can be used in non-instructed advocacy.

K 2.8 Can describe the key elements of the UN (1985) Declaration of Basic Principles of Justice for Victims of Crime and Abuse of Power and the UN Convention on the Rights of the Child (UNICEF 2005), particularly as they relate to working with victims of sexual violence.
Standard 3: Independence

Why this standard is important

“What is unique about that [ISVA role] is that you really get to know your client very well and build up a very trusting relationship…. They know that I am independent from anybody, that I am there to specifically help them, they are my priority. That’s what’s unique about an ISVA, the independent part of it, I think clients feel a lot safer, and a lot more trusting when they realize that you are independent.” (ISVA in, Robinson, 2009).

Agencies and professionals along with family and friends, while well meaning, often have their own agenda’s around sexual violence. Agendas may include structural issues such as victim/survivors being seen primarily as witnesses, “A crime is a crime against the State. The State, not the victim, prosecutes the accused person. The victim is a witness for the prosecution.” (NSW Govt. Victim Services, Attorney General and Justice). Less obvious agendas may include the professional’s need to fix, counsel, do what they feel is best, or to be liked by the victim/survivor.

Independence involves the ability to listen to and when needed, to accurately represent the wishes of the victim/survivor. Ideally, the agency is independent of competing needs (structural independence). Where this is not possible, when in the role of advocate, processes should allow for independence (operational independence).

Personal and professional agendas also need to be managed to allow the advocate to listen and act free of bias (psychological independence).

Being conscious of these structural, operational and psychological competing needs and views allows those in an advocate role to deal with these as well as to disclose these to the victim/survivor when there is bias is unavoidable. Providing these competing points of view is important not with a view to changing the victim/survivor’s mind, but rather to help the victim/survivor explore possible consequences and to make informed decisions.

Practice, policy and procedure around independence for the advocate role is empowering for the victim/survivor and essential to meet the requirements of Standard 2 ‘Advocacy is led by the views and wishes of victim/survivors’.
**Performance criteria to meet this standard**

P 3.1 Utilises supervision to identify and manage bias relating to professional orientation, personal experiences and views and agency expectations.

P 3.2 While aiming to minimise these biases within the advocacy role, where they are unavoidable, explains the nature of the bias and implications for service provision to victim/survivors and with permission of the victim/survivor, discusses these bias issues with their supervisor/manager.

P 3.3 Recognises and honours the need for staff with other roles and from other agencies to work with other agendas. While appreciating these other needs, works towards ensuring the victim/survivor’s wishes are incorporated within these other needs.

**Knowledge and understanding to meet this standard**

K 3.1 Provides examples of structural, operational and psychological independence and describes measures to achieve these areas of independence.

K 3.2 Discusses self-reflective procedures to identify own professional and personal biases as well as agency biases (See also Standards 2 Advocacy is led by the views and wishes of victim/survivors and 19 self-care and professional development).
Standard 4: Advocacy and support services are publicised, accessible

Why this standard is important

“This is the only agency I have come across that has known how to deal with children this age – no one else was prepared to take on this challenge. I found contact details for the [service] on the internet and contacted the advocate by phone. If only they had more of these centres.” (Parent Feedback, George Jones Child Advocacy Centre)

The majority of victim/survivors do not disclose their sexual violence because of real and perceived associated risks. Many of these victim/survivors are also from vulnerable and marginalised groups who may also be socially and/or geographically isolated.

A range of flexible, first contact and subsequent service options may improve access for those who are not receiving services as well as to enhance options of those who are already receiving services.

Victim/survivors often have significant fears including their understanding of counselling, particularly being asked to recount their trauma story and deal with painful emotions. Promoting the advocacy role which offers emotional support, practical assistance, information and advice to help empower and navigate systems may be more attractive to victim/survivors.

Performance criteria to meet this standard

P 4.1 Consults with vulnerable groups and reviews literature for innovations in promoting services, as well as developing service options which reduce barriers, are more accessible and easy to use.

P 4.2 Implements activities aimed at promoting services to vulnerable groups of victim/survivors.

P 4.3 Publicises the specific elements of the advocacy role to promote services.

P 4.4 Seeks partnerships with associated agencies to collectively reduce barriers and risks and promote their services to these vulnerable client groups.

P 4.5 Staff in larger metropolitan and regional areas identifies innovative options to provide access to support services for victim/survivors as well as rural and remote service providers.
P 4.6 Maps and understands the referral process for all relevant local and other commonly used agencies and services to assist the client in being able to access these services.

P 4.7 Staff in rural and remote areas identifies innovative options to provide access to support services for victim/survivors and maximise other supports from larger metropolitan and regional centres.

P 4.8 Follows / develops safety procedures if the advocacy service utilises out-of-office, in-home services, mobile or other street-present, outreach services.

P 4.9 The service provider explains their advocacy role to victim/survivors, particularly if this role is embedded within another role.

P 4.10 Advocacy services are offered to victim/survivors at all stages of their journey through the criminal-justice, health and welfare systems.

**Knowledge and understanding to meet this standard**

K 4.1 Identifies vulnerable groups within the advocate's catchment area who are less likely to disclose their sexual violence.

K 4.2 Names likely barriers for each group to accessing the services and can discuss possible strategies to reduce these barriers.

K 4.3 Names a range of activities to promote services to vulnerable groups.

K 4.4 Articulates the key elements of the advocacy role.

K 4.5 Lists a range of innovative options to make services available to victim/survivors who are geographically isolated.

K 4.6 Lists the agency's safety procedures if providing out of office services to victim/survivors.
Standard 5: Cultural competency

Why this standard is important

“I am a person not a number.”
“Try to listen to what we want instead of guessing. You don’t know us.”
“My advocate was extremely good. She is also a very good friend towards me. She listens...and treats me with respect”. (Department for Health, 2002 pg. 7 – UK)

“These standards recognise cultural diversity as embracing race, ethnicity, language, cultural practices, religious beliefs, values, gender, sexuality, age, ability, socioeconomic status, political views, geographic location and the like.” (NASASV, 1998)

From the system’s advocacy perspective (see Standard 18), it’s important for staff working with the broad range of victim/survivors cultural diversity to recognise and design services to cater for the specialist needs of these groups. This is especially important for those victim/survivors who come from marginalised groups including those with high rates of sexual assault; such as Aboriginal families (see Standard 6), those with an intellectual disability3 and others.

From an individual perspective, being culturally competent requires advocates to first understand their own culture, including their values, beliefs and biases which have shaped that culture. Utilising reflective processes advocates must be able to recognize how power is perceived and used in this context, including race, gender, class, professional status, physical and mental state, etc. (see Hovane, 2007 and for reflective exercises see Walker and Sonn, 2010 pp. 172-176).

In addition to self-reflection Walker and Sonn (2010) suggest cultural competence, “is about developing empathy and connected knowledge, the ability to see the world through other’s eyes, or at the very least to recognise that others may view the work through a different cultural lens” (pg. 161).

While appreciating this cultural lens, advocates need to guard against stereotyping by maintaining their focus on the specific character, circumstances and needs of individuals, their families and their particular position within their broader community and culture (Cox 2008).

3 An Australian study by Murray & Powell (2008) found 90% of women with intellectual disabilities have been sexually abused; and 68% will experience sexual abuse before 18 years of age
Performance criteria to meet this standard

P 5.1 Networks and liaises with local community groups of different cultures to identify specific issues, particularly relating to sexual violence, needs and culturally appropriate resources. Special attention should be paid to the following groups:

- Aboriginal and Torres Strait Islander peoples;
- refugee and migrant groups;
- victim/survivors with mental illness
- children and young people (see Standard 17)
- homeless people
- people addicted to alcohol or other drugs
- those who have a disability
- male victims of sexual assault
- gay, bi-sexual, lesbian, transgender people
- sex workers

P 5.2 Works with local community groups to enhance access and equity of service delivery with an emphasis on accessibility. Where resources allow, outreach services are considered for those with special access needs.

P 5.3 Utilises a family centric model of system supports where family supports and connections are the most common type of support for that cultural group. Similarly, recognises and facilitates where appropriate, other culturally relevant supports such as religious leaders in faith based groups. Privacy issues are discussed when linking with family and close cultural contacts.

P 5.4 Links victim/survivors with available culturally appropriate services and supports as required noting any specific needs for confidentiality.

P 5.5 Utilises effective communication strategies, including interpreter services (discussed, offered, and with consent from the victim/survivor) for:

- people who have disabilities such as hearing, speech, sight, developmental delay;
- children and young people;
- people from Culturally and Linguistically Diverse Backgrounds (CaLD);
- people with a mental illness.

4 The term ‘Aboriginal’ will refer to Aboriginal and Torres Strait Islander peoples in the rest of these standards
Communication strategies show respect for and embrace cultural diversity in work with victim/survivors, their families, other staff, agencies and community groups. The advocate develops a common understanding of the specific cultural issues relevant to the victim/survivor, their family, staff and others they are working with to reflect this respect.

Utilises reflective practice, self-assessment and supervision to identify own level of cultural competence (e.g. see self-reflective exercise on culture by Walker & Sonn (2010) "Working as a Culturally Competent Mental Health Practitioner" in Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice pp 172-176 http://aboriginal.childhealthresearch.org.au/media/54847/working_together_full_book.pdf#page=207

Ensures the environment of the agency reflects a culture which is friendly to and inclusive of multiculturalism as well as of those with disabilities.

In recognition of differences in values and beliefs, the advocate utilises conflict resolution methods of empathy, negotiation, identification of working common territory and mediation to deal with conflict arising from these differences in CaLD victim/survivors, their families and other staff.

Knowledge and understanding to meet this standard

K 5.1 Describes what is meant by cultural safety and how the elements of cultural safety are applied when working with victim/survivors.

K 5.2 Lists the six stages of the Cultural Competence Continuum as described by Cross et al (1989) and describe the essential meaning of each stage.

K 5.3 Discusses own cultural perceptions and perspectives on a diverse range of cultural groups. The advocate identifies and is able to use at least one tool which can be used for cultural competency self-assessment and one tool which can be used for agency cultural competency assessment.

K 5.4 Describes specific issues regarding sexual violence and different cultural groups including discriminating between cultural practices which are acceptable and not acceptable within Australian culture and laws.
K 5.5 Identifies local culturally specific organisations and support services in the local area as well as other state and national services which may be available via the Internet and/or phone.

K 5.6 Identifies most commonly presenting local cultural groups along with key features of each and how they manage commonly occurring features of each group.

K 5.7 Outlines steps needed to facilitate effective communication with CaLD groups including strategies for working with victim/survivors who are developmentally delayed, hearing impaired, and/or have poor English or literacy skills. Advocates can describe when and how they would use interpreter services and other assistance to facilitate more effective communication.

K 5.8 Describes conflict resolution methods including considerations for how different values and styles of conflict resolution for different CaLD groups might be managed.

K 5.9 Outlines the principles, legislation, agency policies, procedures and practices regarding equal opportunity and anti-discrimination in service provision.
Standard 6: Aboriginal and Torres Strait Islander \textsuperscript{5} victim/survivors

Why this standard is important

This Standard supports Outcome 5 of the National Framework for Protecting Australia’s Children (COAG, 2009); ‘Indigenous children are supported and safe in their families and communities’ and Outcomes 3.3 and 4.2 of the National Plan to Reduce Violence Against Women and their Children (COAG, 2012).

A multitude of factors arising out of colonisation and dispossession of Aboriginal peoples such as poor health, alcohol, drug abuse, gambling, pornography, unemployment, poor education and housing, has led to increased risk of sexual violence\textsuperscript{6}, intergenerational transmission of sexual violence and trauma, additional complicating factors and general disempowerment (Cox 2008).

Because of issues associated with shame, close family kinship groupings, threats of violence, fear of the legal and child welfare systems and geographical isolation from services, Aboriginal people often face large barriers to reporting (see also Standard 4 on access).

While some Aboriginal people may want to work with Aboriginal staff, many prefer to work with non-Aboriginal staff and agencies to maintain their privacy and reduce the possibility of community repercussions such as being blamed for police and welfare interventions, pay back and being ostracised for reporting sexual violence.

Historically and in contemporary society, Aboriginal peoples are not a homogenous group, but rather originate from multiple language and custom groups and now not only have great diversity between and within community groups but also within family groupings.

In order to provide services which are accessible and user-friendly to Aboriginal victim/survivors, advocates need to sensitively and skilfully incorporate cultural issues into their service provision while being led by specific individual needs and preferences.

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\textsuperscript{5} The term ‘Aboriginal’ will refer to Aboriginal and Torres Strait Islander peoples in the rest of these Standards.

\textsuperscript{6} The ALRC (2010) Family Violence – A National Legal Response, cite studies which have found rates of reported sexual violence against Indigenous women three or three and half time the rate of non-Indigenous women. (p 1104) See also in this report the section on ‘Indigenous communities’ pp. 1108 – 1110 for a comprehensive summary of Aboriginal sexual violence issues and responses.
Performance criteria to meet this standard

P 6.1 Liaises with Aboriginal service providers and local community Elders and representatives to enhance accessibility and service provision for Aboriginal victim/survivors.

P 6.2 Knowledge of Aboriginal culture and customs is informed by local Aboriginal Elders and community members and in line with agency protocols, are invited to become cultural mentors and stakeholders in guidelines and practice.

P 6.3 Uses a culturally appropriate greeting such as ‘Me, My country, My mob’:
- Me (e.g. your professional role);
- My country (e.g. where you were born/raised, where you’ve mostly lived and, how long you’ve been at your current location while safeguarding private contact details; and
- My mob (something about your family). (Cox, D. Personal Communication)

P 6.4 Is aware of own non-verbal communication as well as that of the victim/survivor including non-verbal communication between family and friends. Is sensitive to particular local protocols such as use of eye contact, how to shake hands, eye and lip gestures etc. (See also element P 11.2 on non-verbal engagement)

P 6.5 Identifies and manages possible communication barriers such as language, literacy, hearing impairment and developmental delay with Aboriginal victim/survivors.

P 6.6 Listens to and learns from Aboriginal victim/survivors their particular cultural situation and specific needs and preferences.

P 6.7 If available, offers the Aboriginal victim/survivors a choice of working with an Aboriginal or non-Aboriginal advocate/staff member.

P 6.8 When obtaining consent for procedures or sharing of any information, ensure there is very clear exploration and explanation of benefits and especially of possible unwanted consequences and the ability to withdraw consent at any time. Respectfully check their understanding of your explanation. Provide a range of options if available prior to obtaining consent.

P 6.9 Utilises a family-centric model of support. Identify and discuss possible kinship supports, including what the victim/survivor does and does not want from
kinship and other support persons recognising that different people may offer different types of support. Other support options provided as required.

P 6.10 Where options are available for external Aboriginal agency support services, non-Aboriginal alternative options are also discussed.

P 6.11 Where resources allow and within agency policy, procedural and safety guidelines, out-of-office and at home service provision is offered.

P 6.12 Ensures as much as possible that forensic investigations, medical procedures, welfare interventions and court procedures are sensitive to the specific cultural needs of the victim/survivor.

Knowledge and understanding to meet this standard

K 6.1 Describes the history and impact of colonisation on Aboriginal and Torres Strait Islander culture, issues related to the ‘Stolen Generation’, historical and contemporary police and legal relationships and the impact these factors have on sexual violence.

K 6.2 Discusses sexual violence in the context of broader social determinants for Aboriginal peoples such as homelessness, education, poverty, poor nutrition, higher use of substances, the legacies of past policies and social, emotional health and wellbeing.

K 6.3 Describes what is meant by intergenerational transmission of trauma and sexual abuse as well as internalised and externalised manifestations of oppression at community, family and individual levels.

K 6.4 Describes what is meant by cultural safety and how the elements of cultural safety are applied when working with Aboriginal victim/survivors.

K 6.5 Accesses data bases of local, state and national Aboriginal services and can name the main local Aboriginal services available to Aboriginal victim/survivors.

K 6.6 Identifies Aboriginal and Torres Strait Islander interpreters, health workers and colleagues as cultural brokers if required.
Standard 7: Underpinning applied knowledge of sexual violence and models of practice

Why this standard is important

“For me the basic requirements are stuff around trauma, how people respond to historical sexual violence and the implications, how people respond to recent sexual violence, quite a lot about the law… and quite a lot about strategies helping to keep people safe in the future… I think [it needs to] focus on SV.” (ISVA in Robinson 2009)

Advocates utilise knowledge of sexual violence and its impact on children, young people and/or adults along with underpinning evidence based practice and theoretical frameworks to provide timely, sensitive and competent supports.

In order to better empathise with and understand the range of issues and impacts associated with sexual violence, advocates require specific knowledge about sexual violence and are able to apply this knowledge in practice.

The use of evidence-based practice not only relates to performance but also provides accountability to victim/survivors who are counting on professionals to know what they’re doing.

Because of the complexity of providing advocacy services to victim/survivors, sexual violence specific knowledge and skill-sets should be based on other related but generic qualifications.

The application of accepted frameworks not only enables clarity for both the advocate and the victim/survivor, but also provides common understandings and language between other service providers.

Performance criteria to meet this standard
P 7.1 Uses knowledge of sexual violence foundation issues below in approaches to working with victim/survivors:

- different types of sexual violence;
- social factors which predispose sexual violence as well as those which reduce incidence and harms;
- motivations and processes of perpetrators;
- disclosure and reporting issues;
- safety issues; including risk and protective factors; and
- impacts of sexual violence on victim/survivors and their families.
P 7.2 Demonstrates the use of evidence based practice, theoretical models and approaches including trauma-informed support, strength-based approaches and systems theory within the advocacy role.

P 7.3 Distinctions between advocacy supportive work and therapeutic counselling are reflected in case planning and delivery of services for/with the victim/survivor.

P 7.4 Participates in scheduled and opportunistic professional development activities (see Standard 19 on self-care and professional development).

Knowledge and understanding to meet this standard

K 7.1 Outlines the key elements of sexual violence foundation issues as well as models and approaches such as trauma informed approaches; attachment theory; strengths based and empowerment models; systems approaches including family and broader systems; decision making frameworks and feminist theory.

K 7.2 Discusses and provides examples of the application of these theoretical models and approaches to the advocacy role with victim/survivors of sexual violence.
Standard 8: Works in a legal and forensic context

Why this standard is important

“I think an advocate is so vital at investigation – or pre-investigation stage- when survivors are grappling with the issue of whether to report or not.” Adult survivor

“For many years, I think, police saw us as likely to contaminate the evidence or say something stupid … Once the police realise our role is not interfering in the process but supporting the victim through the process, and that this actually gives them some space to do their work … then they see the benefit." (Director, Gold Coast CASV7 in Parkinson 2010)

Sexual violence most commonly involves criminal activity by the perpetrator with the possibility of prosecution as well as statutory investigations in child protection cases.

The role of the Advocate is non-investigatory and no action should be taken by the Advocate which could be construed as seeking details about the assault from a victim/survivor. However, in the context of trusting relationships victim/survivors may make an unsolicited disclosure of details relating to an assault. The forensically astute advocate will know the specific recording, reporting and record keeping requirements and procedures.

Advocates will also aim to;

- provide informed choice to victim/survivors regarding legal and statutory options;
- maximise benefits associated with legal options such as increased safety, a sense of justice and victim compensation; and to minimise possible harms such as re-traumatisation, safety concerns and contamination of evidence;
- support (and sometimes prepare) victim/survivors for legal procedures or ensure this is provided by witness support services; and
- manage legal issues such as: legal responsibilities if the advocate is the first point of contact for a disclosure of sexual or physical abuse or neglect; subpoena of client records; and who to consult with about legal issues.

Performance criteria to meet this standard

P 8.1 Provides prioritised options of urgent police and medical supports to establish safety and wellbeing for victim/survivors of very recent sexual assault. (see P 8.6 and P 8.9 for support through procedures).

P 8.2 Follows agency and legislative recording, reporting and record keeping requirements if sexual violence is disclosed.

P 8.3 Provides victim/survivors with a range of disclosure and reporting options consistent with agency and legislative requirements.

P 8.4 Works within legislative and agency policies regarding mandatory and other reporting guidelines when providing service to children and families. Explains these requirements to children and families in the context of boundaries of confidentiality in a way which emphasises safety and support.

P 8.6 Provides assistance and support in accordance with organisational and multi-agency guidelines in a manner which minimises the possibility of contamination of physical or verbal evidence (‘non-evidentiary’ support).

P 8.7 Provides information and can explain key elements of the criminal-justice and statutory child protection systems.

P 8.8 Follows and/or develops with key stakeholder’s role specific procedures for the advocate’s work with police, medical staff, child protective services, prosecutor’s office, witness support and corrective services workers.

P 8.9 Explains legal and medical procedures and in accordance with agency guidelines, and may help prepare and support victim/survivors through legal and medical procedures.

P 8.10 Explains procedures to safeguard confidentiality and privacy, as well as limitations of confidentiality.

P 8.11 Assesses the ability of the victim/survivor to make informed consent for early evidence gathering.

P 8.12 Obtains written consent in accordance with agency and legislative requirements for early evidence gathering and other procedures which the victim/survivor agrees to and which require written consent.

P 8.13 Ensures the needs and rights of the victim/survivor are understood and incorporated into decision making legal and statutory services professionals.
**Knowledge and understanding to meet this standard**

K 8.1  Explains the legal obligations and implications of the legal terms such as “First Point of Contact” or “Early Complaint Witness”, if the advocate is the first to receive a disclosure.

K 8.2  Outlines mandatory reporting obligations and procedures as required by state legislation and agency protocols.

K 8.3  Describes how support is provided to victim/survivors at various legal and medical points without compromising verbal or physical evidence.

K 8.4  Explains why it’s important where possible not to become part of the evidence and provides examples of potential risk situations for becoming part of the evidence and how this is managed.

K 8.5  Outlines confidentiality and privacy procedures including limitations to confidentiality.

K 8.6  Describes key elements of the criminal justice, health and welfare systems as related to work with victim/survivors of sexual violence.

K 8.7  Describes requirements for legal and ethical consent to be given.
Standard 9: Provides support to victim/survivors with co-existing and complex issues

Why this standard is important

“The holistic nature of proving the support is really important. So if a woman comes in here and has issues about her benefits or housing issues, stuff with the police, or legal system, child protection issues, we do it all. And if we don’t know how to do it we bring a worker in who does it in here with her, so she’s only got to come here.” (ISVA in Robinson 2009)

Victim/survivors of sexual violence often have other issues/conditions which may pre-exist the sexual violence, be exacerbated by and/or be a consequence of the sexual violence.

Common examples of co-occurring issues include: other domestic and family violence; intergenerational family violence and sexual abuse; alcohol and other drug use problems; other addictions; sexualised behaviours; mental health concerns; accommodation and/or financial issues; and school-based problems.

While the advocate’s role generally is to help facilitate appropriate services for these issues/conditions, a fundamental understanding of these issues will help identify the most appropriate services as well as to develop good working relationships with the victim/survivor and associated specialist services.

Performance criteria to meet this standard

P 9.1 Uses screening procedures to identify complicating factors associated with sexual violence.

P 9.2 Utilises or develops basic protocols for dealing with complicating factors associated with sexual violence.

P 9.3 Explains role boundaries in progressing supports for complicating factors.

P 9.4 Brief interventions for co-existing or complex issues are only provided if the advocate has brief intervention skills in the specific complicating factor area; if the staff with the advocacy role is resourced to undertake brief interventions and with the agreement of and where possible, consultancy support from specialist agencies and staff. Recognises that brief interventions are not advocacy functions per se and caution should be used as to not jeopardise the advocate-client relationship.
Knowledge and understanding to meet this standard

K 9.1 In reference to sexual violence, describes common presentation issues and approaches appropriate for the advocate role in the following areas:

- family and domestic violence;
- intergenerational family violence and sexual abuse;
- alcohol and other drug problems;
- other addictions;
- sexualised behaviours;
- mental health problems;
- accommodation and/or financial problems; and
- school-based problems.

K 9.2 Easily accesses additional resource materials and clinical supports on these complicating factors.

K 9.3 Outlines the key elements of brief interventions.
Standard 10: Provides acute and crisis intervention

Why this standard is important

“‘Acute care’ refers to the response required for a very recent victim of sexual assault … and a victim-client may be in ‘crisis’ at any point, at recurring points, when triggered by certain events, and at various stages of recovery.” (NASASV 1998)

Advocates are required to respond with a particular set of skills and knowledge to victim/survivors of recent sexual assault.

Those in an advocacy support role are also required to identify, prepare for and help victim/survivors manage a range of crisis events and triggers throughout the victim/survivor’s journey.

Performance criteria to meet this standard

P 10.1 Uses self-monitoring and emotional self-regulation to maintain an alert and calm approach.

P 10.2 Utilises debriefing and supervision to help reduce vicarious trauma, manage own stress responses and process emotional and intellectual issues associated with managing acute and crisis situations. (See Standard 19 self-care and professional development).

P 10.3 Ensures the environment is safe and calming with minimal external stimulus.

P 10.4 Discriminates between a crisis event and the victim/survivor’s response.

P 10.5 Assesses immediate physical and emotional safety needs of the victim/survivor as well as those of children and any other dependents who may be in her/his care.

P 10.6 Provides and/or facilitates acute care responses to immediate physical and emotional safety needs.

P 10.7 Assesses and where necessary facilitates early forensic processes. (See Standard 8 works in a legal and forensic context).

P 10.8 Identifies and helps the victim/survivor prepare for likely crisis points and triggers, provides support to minimise stress through these crisis points and support aimed at recovery and re-integration after the crisis.

P 10.9 Helps the victim/survivor develop coping skills through the use of problem
solving or solution focused techniques, simple stress management approaches and a focus on personal, interpersonal and environmental strengths.

P 10.10 Recognises trauma impacts may reduce cognitive abilities including processing and memory. Any information provided during the acute or crisis points should be presented in a simple and clear manner, checked for understanding and backed up with printed materials (if literate) as well as other follow-up to assess understanding and retention over time. Priority information should be emphasised verbally and highlighted in printed materials.

P 10.11 Provides contact details including afterhours support options if any further crisis arises.

P 10.12 Recognises the different acute and crisis needs of non-offender parent/s, caregiver/s, siblings and partners of the victim/survivor, provides appropriate supports and when appropriate, possibly mobilises these family members to provide additional support to the victim/survivor.

Knowledge and understanding to meet this standard

K 10.1 Outlines trauma and strength based approaches as applied to acute presentation and crisis responses.


K 10.3 Discusses crisis management approaches including stages of crisis, chronic and acute crisis including issues of cumulative trauma.

K 10.4 Describes agency’s acute response procedures, such as assessment, forensic needs, medical and other emergency supports, reporting and recording for the acute needs of victim/survivors with common presentations such as a recent sexual assault, a more distant sexual assault, historical sexual assault and sexual assault with common complicating factors.

K 10.5 Lists a range of emergency support services as well as identify written lists/databases which can also be used by victim/survivors.
Standard 11: Engagement and emotional support

Why this standard is important

“It’s not coaching, it’s not counselling, counselling is the psychodynamic therapy where you go into their past, there’s none of that, it’s grounding, it’s supporting, it’s making sure they’re safe and that they’ve got support out there, and coping mechanisms” (ISVA in Robinson 2009).

Victim/survivors of sexual violence may be fearful, wary of those in authority, angry, distressed, dazed and/or disorientated. Children and young people may also be ‘adult wary’.

Skilful engagement and emotional support can help to rebuild trust, reduce anxiety states, and assist in broadening and adherence of recovery options.

Engaging individuals in hard to reach and vulnerable groups may open the way to service provision to more of those who would otherwise not disclose to service agencies.

Engagement skills are also required to develop productive relationships with other service providers, including those who may have apprehensions and concerns about the advocacy role/service.

Performance criteria to meet this standard

P 11.1 Where possible, prepares for contact with victim/survivors by:

- obtaining relevant known information such as reason for referral, victim/survivor circumstances, name, age etc.;
- offering alternative methods of communication where available such as phone, email or even chat room;
- agreeing on a suitable venue and time where possible; and
- preparing self to be fully present, available and attentive.

P 11.2 Provides careful use of verbal and non-verbal communication skills with particular attention to:

- reflecting feelings to acknowledge feelings but not to deepen distressing feelings;
- proximity of self to victim/survivor who may want more or less distance;
- use of touch which requires astute sensitivity; and
- other non-verbal communication to which the victim/survivor may have heightened sensitivity.
P 11.3 Explains boundaries of confidentiality and information sharing early in first contact, for example, after a brief introduction of your name and role.

P 11.4 Rebuilds trust through proximity, reliability, accountability and integrity. (See Standard 1 on ethical character and accountability).

P 11.5 Maintains clear role boundaries, particularly around the difference between providing emotional support and psychological therapy.

P 11.6 Maintains a high level of professional conduct through using conflict resolution methods when advocating with or on behalf of the victim/survivor’s complaints or suggestions regarding other service providers.

Knowledge and understanding to meet this standard

K 11.1 Outlines key features of engagement and relationship building as they relate to work with victim/survivors of sexual violence.

K 11.2 Discusses elements of engagement including when and how they are used in work with victim/survivors of sexual violence.

K 11.3 Describes and demonstrates communication skills such as empathy, attending, non-judgemental approach, awareness of roadblocks and questioning as well as how they assist in developing relationships with victim/survivors.

K 11.4 Demonstrates an understanding of what is required to rebuild trust.

K 11.5 Outlines issues and skills required to engage with multidisciplinary team members and other professionals associated with sexual violence interventions.
Standard 12: Provision of information

Why this standard is important

“any questions that I had to ask all the way throughout this, I felt that I’ve got the correct information from [ISVA]. And if she couldn’t answer the question there and then she’s always found the information for me. So I’ve never thought that I needed to go somewhere else (Survivor in Robinson 2009).

The trauma of sexual violence and issues associated with reporting can diminish an individual’s ability to retain and process information. To enable empowerment and informed decision making, advocates need a broad understanding of complex systems and processes associated with sexual violence, as well as skills and resources to convey this information to victim/survivors.

The information advocates provide not only assists in decision making and self-advocacy, but also, with their consent, is used to advocate on behalf of victim/survivors when they are unable or unwilling to advocate for themselves. In both cases, the aim is to better service victim/survivors through the empowering use of information.

Skilful provision of information including processes, options, decisions made and feedback on the progress of their case aims to hand back some of the power and control previously lost through the sexual violence and potentially lost through system processes.

Performance criteria to meet this standard

P 12.1 Uses/develops guidelines for the provision of information to victim survivors in consultation with other related service providers.

P 12.2 Provides a range of presentation options for victim/survivors.

P 12.3 Provides information in an amount and depth which suits the individual needs and preferences of each victim/survivor.

P 12.4 Orientates victim/survivors to procedures and their case plan using process maps and a schedule of likely intervention points where additional information will be provided as needed.

P 12.5 Self-help materials, information help lines, support groups and other sources of information are made available to victim/survivors.
P 12.6 Key information is periodically reviewed with the understanding that trauma may reduce retention of information.

P 12.7 Assists victim/survivors with scheduling appointments through the use of appointment cards, diaries as well as reminders via text messaging, calls and email messages.

P 12.8 Assists victim/survivors in weighing up options by using decisional frameworks, identifying related values of victim/survivors and acknowledging emotions associated with difficult decisions.

Knowledge and understanding to meet this standard

K 12.1 Demonstrates a comprehensive knowledge of procedures, processes and service options associated with support for victim/survivors.

K 12.2 Demonstrates a range of communication strategies and range of support materials to convey information.

K 12.3 Describes a range of self-help and other sources of information such as help lines and internet sources for victim/survivors.

K 12.4 Identifies database of local, national and international resources and locally available services. Lists key local services commonly required by victim/survivors.

K 12.5 Demonstrates knowledge of decision making models and frameworks.
Standard 13: Need, risks, strengths and wishes assessment

Why this standard is important

“They’ve done everything. They helped me [get] alarms fitted in my house, they helped me through all that procedure. And making sure that I’d got numbers for Women’s Aid, and refuges and everything like that. So… they’ve always made sure that I’ve always got someone to contact. And they were watching over to make sure things were done, and to make sure like he wasn’t arrested before safety plans were put into my house” (Survivor in Robinson 2009).

While the advocate should be responsive to the wishes of the victim/survivor, other needs such as, safety, health, accommodation, financial and the needs of children may not have been considered by the victim/survivor. The use of screening and assessment tools can help the victim/survivor get a more complete picture of issues to inform their priorities, decisions and goals.

A risks and safety assessment is particularly important in sexual violence as perpetrators are often know to victim/survivors, may still have access to victim/survivors and the act of reporting can generate additional risks.

When the wishes of victim/survivors differs from the primary needs as assessed by the advocate or other professionals, or resources are not available to meet these wishes, the advocate has a duty of care to inform the victim/survivor of these differences and respectfully, where possible reach agreement on mutually acceptable and achievable goals.

Performance criteria to meet this standard

P 13.1 Uses screening and assessment tools and procedures to identify the victim/survivor’s key issues including individual, interpersonal, and environment strengths, risks and resources.

P 13.2 Incorporates assessments on an on-going basis with different procedures for acute need assessment; more thorough assessment, assessment as part of action learning cycles, case closure review and follow-up assessment.

P 13.3 Ensures the nature and timing of assessments are consistent with forensic needs.

P 13.4 With consent of the victim/survivor, information sharing protocols are used between key stakeholders to reduce the need for victims to re-tell information.

P 13.5 The role of the advocate does not require detailed knowledge of the sexual violence. Therefore, the advocate does not seek this information and if the
victim/survivor wants to go into detail about the sexual violence, the advocate, in a supportive way, explains the role of forensic and counsellor staff with whom it is appropriate to share these details.

P 13.6 Confidentiality, consent, recording and reporting procedures are followed as in Standard 15 confidentiality and sharing information.

P 13.7 Information from assessments is used with the victim/survivor as well as others from the multidisciplinary team to formulate and carry out case plans as in Standard 14 develop a clear, focused advocacy support plan.

Knowledge and understanding to meet this standard

K 13.1 Outlines assessment procedures including screening and timeframes for various elements of assessment.

K 13.2 Identifies information sharing procedures and protocols and how these assist with assessment procedures.

K 13.3 Discusses how assessment is related to the action learning cycle.

K 13.4 Describes the difference between assessment for the purpose of making professional judgements and gathering information to better identify the needs and wishes of victim/survivors.
Standard 14: Develop a clear, focused advocacy support plan

Why this standard is important

“In my previous contact with services they have just closed the case without any support offered or referrals made…. [At this centre] I liked the continuity of the service, the constant reassurance, and the communication – all the time I felt like I knew what was happening. Also how they have involved the other networks in my daughter’s life – the school, GP and day-care” (Parent of child victim, George Jones Child Advocacy Centre).

The advocacy plan provides a common map of understanding between the victim/survivor, non-offender family members, the advocate and other service providers regarding actions to be taken to achieve agreed goals based on the assessment.

To provide holistic care, reduce fragmentation of service delivery, and to simplify case planning for the victim/survivor, the advocate works with the multidisciplinary team and other service providers to integrate the advocate’s and other service planning into one overall plan. (See also Standard 16 for interagency support and coordination).

The advocate ensures the planning process is inclusive of and led by the needs and wishes of the victim/survivor. The planning process as well as the plan itself is designed to enhance clarity and direction of the victim/survivor.

The advocate assists the victim/survivor to understand each element of the plan. Through case review procedures, the advocate also participates in ensuring key stakeholders stick to the agreed plan. These review procedures should also allow for adjustments to be made based on feedback.

Performance criteria to meet this standard

P 14.1 Planning templates are used to provide focus, clarity and comprehensive approaches to advocacy and other service supports.

P 14.2 The wishes and views of victim/survivors are sought and are central to the development of plans.

P 14.3 Works with the multidisciplinary team and other service providers to consolidate the advocacy and other service delivery plans into one overall plan.

P 14.4 Assists the victim/survivor in clarifying and presenting their wishes and views at multidisciplinary and other planning meetings.
P 14.5 Explains case plans to victim/survivors so they have a clear understanding of its key components, the roles of service providers as well as their role.

P 14.6 Participates in case review meetings, ideally with victim/survivors, to ensure agreed plans are progressed and to assist the victim/survivor to present their wishes and views in re-planning processes.

Knowledge and understanding to meet this standard

K 14.1 Describes the elements involved in case formulation, case planning and case review.

K 14.2 Outlines the agency’s case planning procedures including the development of the plan for advocacy service support, and more holistic planning through the use of multidisciplinary teams or similar.

K 14.3 Discusses case management issues in the context of case planning and case review.
Standard 15: Confidentiality and sharing of information

Why this standard is important

“My first impression was she [advocate] seemed nice, everyone was friendly. Everything was… seemed safe. You felt that you could talk and they wouldn’t tell everyone” (Teenage survivor, George Jones Child Advocacy Centre).

Sexual violence crosses the most intimate of personal boundaries. It is commonly associated with acute shame for victim/survivors who may be negatively labelled or blamed for being perceived as bringing dishonour to families and communities in some cultures.

Victim/survivors need to know there is overt and clear confidentiality and consenting guidelines, strict adherence to these as well as options for the victim/survivor to withdraw consent at any time because:

- victim/survivors may feel safer to disclose and report sexual violence;
- victim/survivors may feel safer to disclose information which may be important for recovery and/or assist in prosecution of the offender;
- victim/survivors need to have control over their participation before and throughout procedures, particularly invasive or demanding procedures; and
- of legal requirements relating to both client privacy, client safety and the integrity of evidence which emphasise the need for careful attention to confidentiality and privacy.

While confidentiality and privacy are a high priority areas, so too is the judicious sharing of information between key service providers.

The 2009 report of the National Council to Reduce Violence Against Women and their Children (Time for Action), identifies confidentiality guidelines and legislative issues as barriers to effective sharing of information and recommended information-sharing systems and protocols be developed and supported by all organisations in response to sexual assault and family violence.

This can save the victim/survivor the need to re-tell their story, can help provide a more holistic approach to service provision, and can streamline the use of resources.

Therefore, information sharing agreements and procedures should simultaneously safeguard the victim/survivor’s rights to confidentiality and consent as well as provide efficient service delivery through sharing of information. Multidisciplinary teams (MDTs) have been shown to be helpful in this regard.
Performance criteria to meet this standard

P 15.1 Confidentiality arrangements are provided to victim/survivors as well as explained.

P 15.2 Consent of victim/survivors is obtained prior to any sharing of information and physical procedures.

P 15.3 The option to withdraw consent for sharing of information or any procedures is explained as part of obtaining informed consent.

P 15.4 Physical privacy is provided when discussing any issues which may be of a sensitive nature.

P 15.5 Advocate identifies possible security threats such as abusive partners and alerts reception/front counter staff to ensure safety of victim/survivors.

P 15.6 Client records are securely managed in accordance with agency and legal requirements.

Knowledge and understanding to meet this standard

K 15.1 Describes state mandatory reporting requirements and agency policies and procedures regarding mandatory reporting and reporting of self-harm, harm to others and criminal activity.

K 15.2 Describes agencies policies and procedures regarding confidentiality.

K 15.3 Describes interagency policies and procedures regarding confidentiality and consent for the sharing of information.

K 15.4 Describes the agency’s safety policy and procedures for protecting the privacy of victim/survivors including reducing the possibility of unwanted contact between the perpetrator and the victim on or off the premises.

K 15.5 Describes agency protocols and procedures for safe electronic and physical record keeping as well as the safety requirements for safe transmission of client information between service providers.
Standard 16: Facilitate interagency supports and coordination

Why this standard is important

“I guess partnership working would be key... because we have such a cohesive communication strategy with paediatricians, social workers, children and adults services, probation, crown prosecution service, the voluntary agencies. If any agency saw that there was some kind of problem or had an issues or needed to discuss an issue, they would know exactly who to phone up to, and we would resolve things together” (ISVA in Robinson 2009.)

“It seems that this case was lost in our system due to staff changes and without your advocacy this child and family would not have received the support they needed.” (Team Leader, Department for Child Protection letter to George Jones Child Advocacy Centre).

The complex needs of victim/survivors as well as the complex nature of the criminal justice, health and social-welfare systems require a coordinated response from multiple service providers.

While multidisciplinary teams are of great assistance in providing this coordination, the advocate role includes being aware of, facilitating and coordinating an even broader range of service providers.

The advocate may have a case management role which includes case tracking as well as coordination of service delivery such that the victim/survivor receives timely services, there is efficient use of available resources, and the victim/survivor doesn't becomes ‘lost’ in the system.

Victim/survivors report appreciating having a person they know and trust available to them throughout their journey through the criminal-justice, health and welfare systems.

Performance criteria to meet this standard

P 16.1 Develops and maintains and/or accesses a database of local and other service providers.

P 16.2 Explains the nature of other service providers and service options to victim/survivors.

P 16.3 With consent from the victim/survivor, works with and if required, coordinates activities of the multidisciplinary team and/or multi-agency coordinating group.
P 16.4 Assists the victim/survivor to present their wishes and views, or with their permission, presents these wishes and views on behalf of the victim/survivor at case planning and review meetings with the multidisciplinary team and/or multi-agency coordinating group.

P 16.5 Provides a case tracking role and offers pre-arranged, pro-active contact and support at known activity and crisis points such as the release of offenders or anniversary dates.

P 16.6 Identifies local agencies and service providers with whom your organisation works in partnership to address sexual violence.

P 16.7 Reviews the effectiveness of cooperation, relationships and inter-agency protocols in providing coordinated care.

P 16.8 Works with the multi-agency group and/or interdisciplinary team to agree on aims and improvements to relationships and procedures to deliver coordinated care to victim/survivors.

**Knowledge and understanding to meet this standard**

K 16.1 Demonstrates a good general knowledge of local and other service providers related to the legal, health and welfare needs of victim/survivors.

K 16.2 Shows how they can access database/s with a range of other services and supports as well as show how they would provide access to these or similar data bases to victim survivors (e.g. through printed materials, Internet or help lines).

K 16.3 Describes agency and inter-agency protocols for collaboration on working with victim/survivors.

K 16.4 Describes their key functions and processes in providing coordination of service providers and case tracking of the victim/survivor.

K 16.5 Lists critical times when the advocate may seek permission to make contact with the victim/survivor to offer support.

K 16.6 Describes the process by which the advocate demonstrates and incorporates and understanding of the needs and views of other agencies in enhancing coordination of services.
Standard 17: Child and non-offender family support

Why this standard is important

“People just think because you are younger, what you have to say isn’t as important as what they have to say because they are older, which I don’t believe in at all. My advocate definitely takes what I have to say seriously. She doesn’t treat me as if just because I’m younger that my say isn’t important. She actually does the opposite” (13 year old survivor).

“I liked how they introduced themselves to both of us – and they included my daughter as much as me in all of our interactions together. She was involved in all the conversations when we were together as a group; you know I could tell they thought she was important” (Mother of 5 year old survivor). Both quotes from George Jones Child Advocacy Centre.

Advocacy support for children/young people\(^8\) associated with sexual violence includes:

- children who have experienced sexual violence
- siblings of children who have experienced sexual violence
- children of victim/survivors of sexual violence including children of teenagers

Child wishes, in the child’s best interest, and child inclusive approaches

What children say they want is not always consistent with what adults see as in their best interests. The task of the advocate in these instances is to ensure the child’s views are fully understood and presented. Decisions should take these views into account and be ‘child inclusive’. Decisions also need to be guided by and consistent with the UN (1985) Declaration of Basic Principles of Justice for Victims of Crime and Abuse of Power and the UN Convention on the Rights of the Child (UNICEF 2005).

“Children have the right to privacy of their health information and to make their own decisions regarding their privacy where they are competent to do so” (Office the Health Service Commissioner, 2003). Where young people are mature enough to provide informed consent (e.g. mature minors as in the Gillic principle), in accordance with agency policy, they should have the right to decide on parental/caregivers involvement.

Who is the client?

Holistic, family systems work, particularly with younger sexually abused children, often results in the majority of client contact being with parents/caregivers. While the family as a whole and as individual members can be seen as advocacy clients in their own right, the sexually abused child remains the primary client of the advocate.

In some cases where parent(s)/caregiver(s) have complex, multiple needs that are in conflict with the best interests, needs and wishes of children, ideally another advocate will facilitate

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\(^8\) “Children” may refer to children and young people under the age of 18. This acknowledges the differences in work with young children, mature minors, those over 16 years and their families.
parental/caregiver needs to reduce conflicts of interest and ensure both child and parents get the advocacy supports they require.

In all cases where there are child protection issues, child protection issues are prioritised. This will usually involve child protective services as per agency and mandatory reporting guidelines.⁹

**Parent/caregiver support**

The advocate’s role in working with non-offender parents/caregivers is to ensure:

- they receive adequate emotional and practical support, information and guidance;
- they incorporate the wishes and needs of their victim/survivor child(ren) into their decision making and planning;
- their views are heard and presented to others in the multidisciplinary team;
- consent for procedures and sharing of information is sought on behalf of children who are not old enough or mature enough to provide informed consent; and
- their right to guide and parent children in their care is supported and respected (see footnote)

The decisions of the advocate and professionals working with children and parents should be clearly explained to the children and parents (except where mature minors have withheld consent to involve parent). This explanation should relate directly to the expressed wishes of children and incorporate safety, parent wishes and other considerations.

**Performance criteria to meet this standard**

P 17.1 Screening is used to identify all children and dependents in the family. This includes screening for:

- children of adult and teenager victim/survivors of sexual violence,
- other dependents in their care; and
- siblings of sexually abused children and young people.

This screening inquires as to the wellbeing of all children and dependents identified in the family.

P 17.2 While the needs of adult, victim/survivors parents/caregivers are important, priority is sensitively given to the safety and welfare needs of children.

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⁹ Where parenting presents a child protection threat, the rights and safety of the child predominates. However, there is still an aim to resolve parental risk and restore parental rights where possible. This is usually managed by child protection staff.
P 17.3 Child protection laws and interagency guidelines are followed when providing services to children and parents/caregivers of children.

P 17.4 Confidentiality including mandatory reporting boundaries and consent issues, are explained to non-offender parents/caregivers and in a developmentally appropriate way, to children. (See P 17.5 re involvement of parents/caregivers).

P 17.5 Mature aged minors and those with developmental disabilities are assessed for their ability to provide consent for procedures, and involvement of non-offender parent/caregivers.

P 17.6 Developmentally appropriate knowledge and skills are used to engage with and identify the needs and wishes of children.

P 17.7 The needs of non-offender parents/caregivers are assessed in the context of facilitating their practical and emotional support of their child/ren as well as their own needs for practical and emotional support.

P 17.8 The needs of siblings are assessed where supports are required.

P 17.9 The needs and wishes of children as well as those of non-offender parents/caregivers (see 17.5 for consent of parents/caregivers) are presented and taken into account in making ‘child informed’ decisions.

P 17.10 Non-offender parents/caregivers are assisted in presenting their views, wishes and needs for their child/ren and themselves to other professionals and agencies (self-advocacy) or having their views represented by the advocate (representation advocacy). Where appropriate, advocates also assist children to present their views to other professionals and agencies.


P 17.12 In accordance with Articles 4, 5 and 42 of the UN Convention on the Rights of the Child (UNICEF 2005), the rights of children should be explained to children and family rights explained to parents/caregivers.

P 17.13 Decisions and case plans are explained in developmentally appropriate ways to children and also to non-offender parents/caregivers.
P 17.14 Non-offender parents/caregivers are provided with emotional support and practical assistance to help them deal with their own reactions to their child’s sexual assault as well as to assist them in providing support to their child/ren.

P 17.15 While the safety needs of children are the primary concern of child protective services, advocates will be aware of and ensure safety plans and protective behaviour initiatives are provided where appropriate.

P 17.16 In accordance with the wishes of teenage victim/survivors, non-offender partners may be included in support and treatment planning.

**Knowledge and understanding to meet this standard**

K 17.1 Describes developmental milestones and needs of children, as well as the possible impact trauma and sexual assault can have on this development.

K 17.2 Describes and demonstrates engagement and communication skills appropriate for children at various developmental stages.

K 17.3 Explains the possible impact sexual violence from someone in a position of trust can have on attachment formation of children as well as trust in adults.

K 17.4 Outlines elements of the grooming process and the significance of this regarding decision making of children and disclosures as well as on-going safety needs.

K 17.5 Explains the meaning of and distinguishes between, ‘child informed’, ‘best interests’, and ‘child inclusive’ practices and decision making.


K 17.7 Describes the key elements of protective behaviours education as well as responsible relationship programs for teenagers. Explains why it’s desirable to facilitate protective behaviour instruction via non-offender parent/caregivers.

K 17.8 Explains basic differences in parenting styles.

K 17.9 Describes agency and legal requirements for victim/survivors to be able to give informed consent.
Standard 18: Complaints management and system’s advocacy

Why this standard is important

“I had a client who wanted to complain but didn’t want to jeopardise the case, she didn’t want to be seen as a troublemaker.” (Advocate in Payne 2009)

While managing client suggestions and complaints is an important part of any agency’s accountability and development, it’s particularly important for victim/survivors of sexual violence as these procedures can be empowering and acknowledge the value of their input.

Much of the system’s advocacy is on the local level and related to multidisciplinary and multi-agency coordination (see Standard 16). Acting to ensure client, advocate and other feedback (positive, negative and suggestions) is routinely incorporated into these local systems is essential as part of quality assurance and improvement procedures. Prior agreement of local stakeholders of this system’s advocacy role as well as space and openness to raise and progress issues is desirable for this to be a constructive and relationship building process rather than an undermining, destructive process.

Literature and experience in the sexual violence field points to the need for many higher levels of system’s advocacy. While it is beyond the role of frontline advocates to be the champion of these larger causes, pathways for handing over the higher levels of policy, legislative or whole of community behavioural change should be clearly identified. This will usually involve handing over to and consultation with supervisory staff that may subsequently progress issues through higher level committees, the Children’s Commissioner or similar senior staff and agencies. This provides a pathway for victim/survivors and frontline workers to impact higher level systems change processes which is empowering for victim/survivors and staff, and important as a driver for ‘grass-roots’ directed change.

Performance criteria to meet this standard

P 18.1 Routinely requests intermittent feedback from the victim/survivor and explains complaints procedures.

P 18.2 Acts on feedback suggestions and complaints with or for the victim/survivor within reasonable timeframe and provides feedback on actions taken.

P 18.3 Where appropriate and in accordance with agency guidelines, options for complaints to be managed by someone independent of the agency should be offered.
P 18.4 Utilises multidisciplinary team and/or inter-agency meetings with agreement of those involved to present and progress system’s issues as per agency guidelines.

P 18.5 Utilises conflict resolution methods and collaboration to strengthen relationships when resolving differences.

P 18.6 Works within agency guidelines and reporting procedures to regularly review and progress higher level policy, legislative and community system’s issues.

Knowledge and understanding to meet this standard

K 18.1 Outlines the agency’s complaints and client feedback procedures.

K 18.2 Describes key elements of conflict resolution procedures such as mediation, negotiation and identifying common values and agreed working territory.

K 18.3 Identifies and articulates the roles and goals of different professionals and to understand some of the professional language of those in other professional roles.

K 18.4 Describes the agency’s procedures for progressing system’s issues relating to local agency issues.

K 18.5 Describes the agency’s procedures for progressing higher level system’s issues such as larger, state-wide and national policy, legislative reform, larger preventative programs and influencing whole of community values.

K 18.6 Describes the role and function of the Children’s Commissioner or equivalent in their state including what kinds of issues they would deal with and how these might be progressed through their agency. (See link below for Children’s Commissioners’ information for each state: www.ccyp.wa.gov.au/content/Other-Children%27s-Commissioners.aspx)
Standard 19: Self-care and professional development

Why this standard is important.

“Because [ISVA] has such ongoing contact with these clients it’s quite hard not to get involved and to feel quite passionately about what they’re going through…. I think that’s going to be quite a challenge for anybody working in this area, to be able to be emotionally available to a client but at the same time not take that home with you…. things like secondary trauma, and vicarious trauma, and burn out, all of those things are quite a challenge, I think.” (ISVA in Robinson 2009)

Work with victim/survivors of sexual violence will expose the advocate to high levels of vicarious trauma. In addition, the stress of dealing with (sometimes challenging) multiple service providers and disappointing outcomes regarding conviction of perpetrators can culminate in a hazardous cocktail of vicarious trauma, stress, frustration and unresolved anxiety.

An advocate’s own trauma history may influence the type of advocacy support given and may also be triggered by the experiences of the victim/survivor.

Access to and utilisation of organisational supports such as supervision, coaching, mentoring, debrief sessions and personal counselling services through Employee Assistance Programs (EAPs) will help manage these issues for the benefit of the advocate, as well as the advocate’s delivery of services to the victim/survivor and work with colleagues.

A commitment to on-going professional development is also likely to reduce work-related stress and anxiety as well as improve performance for the victim/survivor.

Performance criteria to meet this standard

P 19.1 Utilises regular supervision to reflect on, assess and manage issues of stress and vicarious trauma.

P 19.2 Formal and informal debrief sessions are routinely incorporated into case management as well as when dealing with critical incidents.

P 19.3 Takes agency opportunities such as the use of EAPs and confidential telephone counselling to reflect on any past trauma history including sexual violence and its possible impact on the advocate’s wellbeing and service provision.
P 19.4 Creates a professional development plan and utilises a range of learning opportunities such as classroom/workshop learning, on-line learning, subscription to relevant on-line and other newsletters, coaching and mentoring.

P 19.5 Reflective practices such as the action learning cycle of review, plan, act and review are used to enhance on the job learning.

**Knowledge and understanding to meet this standard**

K 19.1 Explains the differences between work-related stress, vicarious trauma and burn out including prevention and management of each.

K 19.2 Outlines elements of their own plan to maintain their well-being and to deal with both professional and personal challenging issues in accordance with agency protocols and resources as well as any other resources available to the advocate.

K 19.3 Outlines their own professional development plan including learning and associated professional goals, a range of learning opportunities they plan to use, scheduling, timeframes, resources and supports.

K 19.4 Explains how action learning cycles work and types of learning possible at each phase of the cycle.

K 19.5 Discusses the meaning of reflective practice and how this relates to learning and professional development.
References

Links to documents correct as at 5 January 2013.

**Other Standards reviewed in the preparation of this document**

(See also Appendix 1 for a more detailed view of four of these Standards)

www.actionforadvocacy.org.uk/articleServlet?action=display&article=1045&articletype=e=41


Department for Community Development – now Department for Child Protection (2007) 
*Child Sexual Abuse Treatment Services (CSATS) Standards*, Government of Western Australia. 
www.dcp.wa.gov.au

www.dh.gov.uk/en/Consultations/Responsestoconsultations/DH_4017049


National Children’s Alliance (2011) *Standards for Accredited Members* (USA). 
www.nationalchildrensalliance.org/index.php?s=76


South East Centre Against Sexual Assault (SECASA, 2012) *Guiding principles when working with survivors*, Victoria. 

Other publications reviewed in the preparation of this document


Appendix 1: Related National Standards

Advocacy competencies from Australia, practitioner standards from the UK, organizational standards from the USA and a code of practice for practitioners from England and Wales provided below are some key resources used to develop the Standards in this document.

Click the icon to go to that Standard if viewing electronically and Internet connected.

Certificate IV in Community Services Advocacy CHC41012

About this qualification
15 units are required for award of this qualification including:

- 9 core units listed below and
- 6 elective units from a broad selection of areas.
  (Go to http://training.gov.au/Training/Details/CHC41012 to view details of the 36 elective units as well as the 9 core units.)

- While this course contains many valuable units associate with the role of advocate in Community Services, it does not contain units specific to working with people who have experienced sexual or domestic violence.

Nine core, required units

- BSBINM201A Process and maintain workplace information
- CHCAD401D Advocate for clients
- CHCCD412B Work within a community development framework
- CHCCOM403A Use targeted communication skills to build relationships
- CHCCS400C Work within a relevant legal and ethical framework
- CHCNET402B Establish and maintain effective networks
- HLTHIR403C Work effectively with culturally diverse clients and co-workers
- HLTHIR404D Work effectively with Aboriginal and/or Torres Strait Islander people
- HLTWHS300A Contribute to WHS [Work, Health and Safety] processes
Code of Practice for Advocates by Action for Advocacy (2006a)
www.actionforadvocacy.org.uk. (England and Wales)

Code of Practice for Advocates summary of the ten key areas is provided below. (Use Code of Practice for Advocates link above or Quality Standards for Advocacy Schemes link at bottom of page if the links below are too slow or don’t work).

- **Clarity of purpose** – Clarity about role boundaries and what can offer within these boundaries. No sexual or inappropriate relationships with service users.

- **Independence** – Takes steps to avoid conflicts of interests including ‘operational independence’ when the agency is structurally aligned with competing interests and manages personal bias, ‘psychological independence’.

- **Putting people first** – Instructed advocacy: helps to make informed choices, doesn’t give advice, representing expressed wishes. Non-Instructed advocacy: using alternative methods of communication, ensuring human rights are upheld, providing a person-centred approach.

- **Empowerment** – Service user is provided with the advocate’s approach, feedback is encourage and if unhappy with the approach and alternatives considered.

- **Equal opportunity**: Equal opportunity policies. Right to preference for a particular advocate.

- **Accessibility** - Within safety and occupational and health guidelines, meet service users at mutually convenient places. Information is accessible and understandable.

- **Supporting advocates** – make use of and contribute to professional development opportunities.

- **Accountability** – Act within the law and organisation’s Code of Practice. Accountable to their organisation and service user.

- **Confidentiality** – Fully conversant with and can explain organisation’s confidentiality policy including boundaries of confidentiality. Respectful of service users’ right to confidentiality.

- **Complaints** – Fully conversant with and can explain organisation’s complaints procedure including complaints about the advocacy service. Open to criticism and suggestions without becoming defensive. Professional conduct when managing complaint from another service worker.

Quality Standards for Advocacy Schemes’ by the Action for Advocacy (A4A, 2006b) contain a rationale and organisational standards as well as the Code of Practice for each of the ten areas above which come from the Action for Advocacy Charter.
**National Occupational Standards**

http://nos.ukces.org.uk (2012) UK (Search ‘advocate’ for additional, related standards)

- Advocate on behalf of victim/survivors of sexual violence
- Support victim/survivors of sexual violence through the court process
- Support victim/survivors of sexual violence to provide evidence
- Act as an independent advocate
- Address callers regarding sexual violence with sensitivity
- Carry out an assessment to identify the needs of and risks to victim/survivors of sexual violence
- Communicate and engage with victim/survivors of sexual violence
- Advocate with and on behalf of children and young people
- Provide access to information for victim/survivors of sexual violence
- Arrange safe accommodation for victim/survivors of domestic and/or sexual abuse/violence
- Work in partnership with agencies to tackle domestic and/or sexual abuse/violence

**National Children’s Alliance Standards for Accredited Members**


- Multidisciplinary Team (MDT)
- Cultural Competency and Diversity
- Forensic Interview
- Victim Support and Advocacy
- Medical Evaluation
- Mental Health
- Case Review
- Case Tracking
- Organizational Capacity
- Child Focused Setting
Appendix 2: Advocate’s code of ethics

Code of ethics for advocates

Ethical practice should underpin the role of advocates. Examples of ethical codes of practice can which are consistent with advocacy roles include:

- the Australian Association of Social Workers Code of Ethics (AASW, 2010)
- the Australian Psychological Society Code of Ethics (APS, 2011)

Headings from the ASSW (2010) Code of Ethics

(Use the ASSW Code of Ethics if the links below are too slow or don’t work)

3 Social work values

- Respect for persons;
- Social justice; and
- Professional integrity

5 Ethical Practice: Responsibilities

5.1 General ethical responsibilities

5.1.1 Respect for human dignity and worth
5.1.2 Culturally competent, safe and sensitive practice
5.1.3 Commitment to social justice and human rights
5.1.4 Social work service and propriety
5.1.5 Commitment to practice competence
5.1.6 Professional boundaries and dual relationships
5.1.7 Conflicts of interests

5.2 Responsibilities to clients

5.2.1 Priority of clients’ interest
5.2.2 Client self-determination

5.2.3 Informed consent
5.2.4 Information privacy/confidentiality
5.2.5 Records
5.2.6 Termination/interruption of service

5.3 Responsibilities to colleagues

5.4 Responsibilities in the workplace

5.4.1 Service provision
5.4.2 Management

5.5 Responsibilities in particular contexts

5.5.1 Education, training, supervision and evaluation
5.5.2 Research
5.5.3 Self-employment
5.5.4 Remote service delivery

5.6 Responsibilities to the profession
### Appendix 3: Skill sets associated with the Standards

Advocacy Roles, Standards and Training for those working with Victims/Survivors of Sexual Violence

**Advocacy Role Domains**

<table>
<thead>
<tr>
<th>Domain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accessible</td>
</tr>
<tr>
<td>Client led</td>
</tr>
<tr>
<td>Informed decision making</td>
</tr>
<tr>
<td>Empowering</td>
</tr>
<tr>
<td>Emotional and practical supports</td>
</tr>
<tr>
<td>Independence</td>
</tr>
<tr>
<td>Criminal justice system supports</td>
</tr>
<tr>
<td>Multi-agency collaboration</td>
</tr>
<tr>
<td>Complaints and feedback</td>
</tr>
</tbody>
</table>
## Key Advocacy Domains with Skill Indicators

<table>
<thead>
<tr>
<th>Key Advocacy Domains</th>
<th>Skills Indicators</th>
</tr>
</thead>
</table>
| Accessible and known | - Outreach promotional activities  
- Develops and maintains links with local professional and non-professional individuals and groups including those who are marginalized.  
- Transparency and accountability for professional conduct, especially confidentiality and skillful support. |

<table>
<thead>
<tr>
<th>Led by views and wishes of clients</th>
<th>Skills Indicators</th>
</tr>
</thead>
</table>
| Victim/survivors verbal and non-verbal communication is listened to carefully to identify their views and wishes throughout their involvement with the service. The advocacy service is led by these views and wishes. Developmentally immature persons also have their views and wishes heard and represented in decision making. These decisions are consistent with the UN Rights of the Child, and may incorporate family and safety issues. | - Attentive and reflective listening skills avoiding roadblocks to listening.  
- Views and wishes of victim/survivors and key family members are represented and as much as possible followed while in the service.  
- Developmentally appropriate techniques are used to identify views and wishes of developmentally immature victim/survivors.  
- Key elements of the UN Rights of the Child and safety issues are incorporated into decisions and fed back to the child/family.  
- Who is the primary and secondary is known and justified. |

<table>
<thead>
<tr>
<th>Facilitates informed decision making</th>
<th>Skills Indicators</th>
</tr>
</thead>
</table>
| Relevant and quality information is provided in a timely manner to facilitate informed decision making. Different formats are used to suit the particular needs of victim/survivors and their families. Options are offered and consequences discussed but decisions rest with the victim/survivor. Legal and ethical consent procedures are followed to ensure the ability to provide informed consent. | - High quality information is developed and/or accessed to cater for different stages of service provision.  
- Information is provided in a variety of formats appropriate to individual needs.  
- Options and consequences are clearly discussed and presented without judgments.  
- Discriminates between, providing information, guided decision making and giving advice.  
- ‘Gillic competence’ and agency procedures are followed in obtaining informed consent for procedures and release of information. |

### Professional qualifications, role and agency functions linked to these advocacy domains

While the above domains relate specifically to the advocacy role, these skills and approaches rest on a broad range of other professional skills. They are also influenced by the particular agency function and professional role within the agency. See next page for professional skills underpinning and related to these advocacy domains.
### Key Advocacy Domains

<table>
<thead>
<tr>
<th>Facilitates empowering opportunities</th>
<th>Skills Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clients regain a sense of power, choice and control.</td>
<td>• Skillful use of supportive techniques to emotionally hold and ground victim/survivors in crisis.</td>
</tr>
<tr>
<td>The disempowering nature of sexual assault as well as elements of the criminal-justice and social welfare system is recognised. Advocates provide empowering opportunities at a pace suitable to victim/survivors and their families. Where possible, self-advocacy is facilitated, although a range of advocacy and support options are offered.</td>
<td>• Provides a range of advocacy options including self-advocacy, supported self-advocacy or representational advocacy.</td>
</tr>
<tr>
<td>Distress and disability is acknowledged and managed with a shift to strength based approaches where practicable and appropriate. There is an aim to facilitate client feelings and perceptions from being a victim, to survivor and then to thriver. In practice, these stages are commonly mixed.</td>
<td>• Where possible, works towards self-advocacy.</td>
</tr>
<tr>
<td>• A range of support options including other professional, family and other non-professional options are discussed.</td>
<td>• Utilizes the strength-based approach of ‘acknowledge distress but where possible, focus on [strength] success.</td>
</tr>
</tbody>
</table>

### Provides emotional and practical supports

<table>
<thead>
<tr>
<th>Skills Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Key elements of emotional support appropriate to various acute, crisis, and non-crisis situations is provided.</td>
</tr>
<tr>
<td>• Practical supports such as clothing, toiletries and food are available and provided where necessary.</td>
</tr>
<tr>
<td>• Immediate safety, health, shelter and other basic needs are assessed and prioritised with the wishes and needs of victim/survivors.</td>
</tr>
<tr>
<td>• Local, practical support resources and options are known and made available to victim/survivors and their families.</td>
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</tbody>
</table>

### Independence

<table>
<thead>
<tr>
<th>Skills Indicators</th>
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<tbody>
<tr>
<td>• Utilises self-reflection and supervision to identify areas of structural, operational and psychological bias.</td>
</tr>
<tr>
<td>• Where bias and/or conflicts of interests are unavoidable, they are explained to victim/survivors.</td>
</tr>
<tr>
<td>• Uses an intersectional approach (the interplay between individual variation and multiple cultural impacts – particularly as related to oppression) to increase empathy and reduce power differentials and stereotyping.</td>
</tr>
</tbody>
</table>

### Underpinning professional knowledge, skills and approaches

<table>
<thead>
<tr>
<th>Ethical conduct</th>
<th>Self-care</th>
<th>Engagement</th>
<th>Crisis management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cultural competency</td>
<td>Communication</td>
<td>Documentation</td>
<td>Assessment and Planning</td>
</tr>
<tr>
<td>Equal opportunity</td>
<td>Confidentiality</td>
<td>Child/family safety</td>
<td>Complex case management</td>
</tr>
<tr>
<td>Professional development</td>
<td>Trauma informed</td>
<td>Systems and prevention</td>
<td>Sexual violence issues</td>
</tr>
</tbody>
</table>
### Key Advocacy Domains

<table>
<thead>
<tr>
<th>Support through criminal justice system</th>
<th>Skills Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Victim/survivors and their families receive advocate ‘end to end’ supports through the criminal justice system without contaminating evidence. Options are provided at each step of the criminal justice procedure with likely benefits and undesirable consequences explained in advance. Procedures are explained and emotional and practical supports provided before, after and at times during procedures. The advocate works to ensure service provision is consistent with the UN Rights of Victims of Crime.</td>
<td>Demonstrates being forensically astute in providing non-evidentiary supports. Orientates and prepares victim/survivors and family to various forensic and legal procedures using a variety of methods. Explains how consent is obtained for various procedures including an explanation of how consent can be withdrawn at any time. Understands and translates legal and medical forensic language to victim/survivors. Aims to ensure legal and associated services treat victim/survivors in accordance with the UN Rights of Victims of Crime.</td>
</tr>
</tbody>
</table>

### Multi-agency collaboration and representation

<table>
<thead>
<tr>
<th>Skills Indicators</th>
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</thead>
<tbody>
<tr>
<td>Victim/survivors will have access to a coordinated range of agency and multidisciplinary supports while having the consistency of their advocate who provides ‘end to end’ supports. While confidentiality is strictly upheld, thoughtful procedures allow for the judicious flow of information, with the consent of the victim/survivor. Where victims are not able, or choose to not address multidisciplinary and multi-agency meetings, their views and wishes are voiced by the advocate who represents them in decision making and explains decisions of these groups to victim/survivors.</td>
</tr>
</tbody>
</table>

### Seeks and progresses positive and negative feedback and suggestions

<table>
<thead>
<tr>
<th>Skills Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>The views of victim/survivors and their family about the quality of the advocacy and other services provided are routinely obtained formally and informally at various points in their journey through ‘the system’. This feedback is used is quality assurance for the advocate, their agency as well as other agencies, including scheduled feedback multidisciplinary and multiagency meetings. Actions taken on feedback are provided to victim/survivors. Additional complaints procedures are provided if complaints cannot be resolved within the agency. Where victim issues relate to larger policy, legislative or whole of community interventions, clear channels to progress these issues through supervisors and higher levels are used. Victim/survivor may be invited to participate in the agency’s policy and practice development and review.</td>
</tr>
</tbody>
</table>

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Advocacy Standards
## Appendix 4: Reference group membership

(Chairperson)
### Helen Creed
- Policy Manager Vulnerable People
- West Australian Council Of Social Service (WACOSS)
  - [www.wacoss.org.au](http://www.wacoss.org.au)

### Alyson Brett
- Detective S/Sergeant, Officer in Charge
- Child Assessment Interview Team
- Western Australian Police

### Jon Rose
- Project Manager
- George Jones Child Advocacy Centre
- Parkerville Children and Youth Care (Inc)

### Julie Jackson
- Director
- Legal Aid Western Australia

### Julie Newsham
- Director
- ChildFIRST
  - Department for Child Protection

### Natalie Hall
- Director
- George Jones Child Advocacy Centre
- Parkerville Children and Youth Care (Inc)

### Pip Brennan
- Victim representative, Sexual Assault Services Advisory Group
  - Health Consumers’ Council Consumer Advocate
  - [www.hconc.org.au](http://www.hconc.org.au)

### Tunya Petridis
- Children’s Consultant
- Anglicare
  - [www.anglicarewa.org.au](http://www.anglicarewa.org.au)
Appendix 5: An overview of the George Jones Child Advocacy Centre (GJCAC)

The Child Advocacy Centre approach to recovery for children and young people who have experienced abuse.

Paper authored and presented by: Natalie Hall Director, George Jones Child Advocacy Centre and Amanda Paton Clinical Psychologist, Director Therapeutic Services at the Children: A resource most precious 2011 Conference.

Click the Link icon for the full paper if viewing electronically and Internet connected.

In March 2011, Parkerville Children and Youth Care (Inc) opened the George Jones Child Advocacy Centre (GJCAC) in Armadale Western Australia. It is the first Child Advocacy Centre (CAC) to be established in Australia and is located 29 kilometres south of the Perth central business district.

In Western Australia, Parkerville Children and Youth Care have been providing services for children who have been harmed or neglected since 1903. In 2007, the Board confirmed their intention to raise capital funds to build the CAC in Armadale and to work with government and other stakeholders to develop the model of service delivery for children, young people and families. It was agreed by stakeholders the purpose of the CAC would be to prevent and respond to child abuse by: providing a multidisciplinary team response to meet the needs of each child and family with compassion, understanding and skill; and by uniting stakeholders and agencies to strengthen the response to the safety, treatment and well-being of abused children.

The GJCAC also has a strong prevention of child maltreatment focus. Interventions at the CAC are not only event focused e.g. investigation of harm that has occurred to the child, but are ecological and holistic, with assessment of the family’s strengths and concerns and
psycho-education input for parents and children to help them anticipate the impact of trauma and for parents information and strategies about how best to support their children.

Prevention thus occurs at three levels:

- **Primary prevention** – families are linked to universal services and support services; education programs for children and adults are provided; and community events and campaigns are employed to increase awareness.

- **Secondary prevention** – children and families who are vulnerable or at-risk are identified and linked to services to alleviate problems and prevent escalation before harm occurs.

- **Tertiary prevention** – when a child has been harmed, services are provided to assist recovery, strengthen family and reduce long-term implications of harm and prevent harm re-occurring, focusing on assisting the child to grow to be a strong healthy adult and future parent, breaking cycles of abuse.

A key strength of the CAC model is that it is not confined to government service provision. Community involvement, fundraising, benevolent donations and foundations provide creativity in how funds, goods and services in kind can be gathered and applied. This is evident at the George Jones Child Advocacy Centre where children and young people had input into the design or the building and art work, and evaluation tools have been designed for children with computer graphics and games. Children receive clear messages from the CAC that they are important, listened too and cared for.

**Links to further information**

The George Jones Child Advocacy Centre Web site


Click the icon below for links from the GJCAC site:

- [The GJCAC Quick Facts, June 2012](#)
- [The GJCAC Practice Principles and Standards.](#)
- [The GJCAC Professional publications.](#)