SA/DVTC STANDARDS OF CARE

FOR THE ADULT/ADOLESCENT POPULATION

THIRD EDITION
2026

Ontario Network of Sexual Assault/ Domestic Violence Treatment Centres

The following standards of care describe the service delivery expectations for health care professionals who provide care to victims/survivors of sexual violence and/or domestic violence (intimate partner violence) at Ontario's Sexual Assault/Domestic Violence Treatment Centres (SA/DVTCs). First developed in 2014 in collaboration with SA/DVTC Program Leaders, these standards have been updated and revised in 2026 to reflect current evidence informed best practice, Canadian testing and treatment guidelines for sexually transmitted infections and pregnancy, health care guidelines, and forensic requirements as determined by the Centre of Forensic Sciences.

For further information, please visit: www.sadvtreatmentcentres.ca

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About the Network

Established by the Ministry of Health and Long-Term Care (MOHLTC) in 1993, the Ontario Network of Sexual Assault & Domestic Violence Treatment Centres ("ONSA/DVTC" or "the Network") provides leadership and support to hospital-based, community-aligned Sexual Assault/Domestic Violence Treatment Centres (SA/DVTCs) across Ontario.

The goal of the Network team, which includes a Provincial Director, a data analyst, clinical practice leaders, administrative staff, researchers, and education and outreach staff, is to support SA/DVTCs providing comprehensive, timely, *trauma and violence-informed care* and treatment to victims/survivors of *sexual violence* and *domestic violence (intimate partner violence)* , which addresses their individual health, forensic, and psychosocial needs. Through collaboration in research, education, and training activities, the Network strives to establish standardization in service provision across the province. The Network represents the SA/DVTCs, lobbying for change and working to influence public policy.

Network clinicians are multidisciplinary, and include nurses, social workers/ counsellors, physicians, and administrative staff. The Network works in collaboration with medical and legal professionals, as well as community partners, in raising awareness through education, advocacy, and enhancing victim/survivor care and treatment through research initiatives that underly evidence-based practice.

Sexual Assault/Domestic Violence Treatment Centres:

SA/DVTCs provide 24-hour trauma and violence informed care to all persons (women, men, and gender-diverse individuals) across the lifespan who have experienced sexual violence and/or domestic violence (intimate partner violence). Services may include: emergency medical and nursing care, testing and prophylactic treatment of sexually transmitted infections (including HIV), emergency contraception, crisis intervention, risk assessment, safety planning, documentation of injuries (may include photo-documentation), collection and storage of forensic evidence, arrangement of health care follow-up, counselling, support in reporting to the police, and/or referrals to community resources.

Philosophy

The Ontario Network of Sexual Assault and Domestic Violence Treatment Centres is committed to operating from within a feminist and *intersectional analysis* of violence which recognizes the embedded social, cultural, and systemic imbalances within society that promote and maintain violence. We also acknowledge the many intersecting factors that comprise any one person's identity, context, health, and well-being. As such, we recognize the importance of promoting choice, respect, and empowerment while honouring differences.

Vision

A unifying voice and catalyst for change in responding to the health, forensic, and psychosocial needs of those who have experienced sexual violence and/or domestic violence (intimate partner violence) across the lifespan. Services are informed with an understanding of trauma, equity, diversity, and inclusion principles.

Mission

To provide leadership and support through advocacy, education, and research to thirty-seven (37), 24/7, hospital-based/community-aligned Sexual Assault and Domestic Violence Treatment Centres across Ontario.

Core Values

1. All individuals have a right to a life free of violence.
2. Women are disproportionately affected by domestic violence and sexual violence, as evidenced by research. As such, we recognize that violence is *gender-based,* widespread, and a human rights violation. It reflects and reinforces gender inequities and compromises the health, dignity, security, and autonomy of its victims/survivors.
3. Sexual violence and domestic violence have long-term, negative impacts on individuals, families, and society.
4. Sexual violence and domestic violence are crimes and individuals have the right to support whether or not they choose to engage with the legal system.
5. Sexual violence and domestic violence must be addressed collaboratively by the healthcare, legal, social, and political systems.
6. Everyone has the right to trauma and violence-informed services to aid in their recovery, regardless of gender, gender identity or expression, culture, race, disability, religion or spirituality.
7. Services must be trauma and violence-informed and accessible, with staff appropriately trained to provide care to all community members.
8. Access to trauma and violence-informed specific services can mitigate harm and facilitate healing and post-traumatic growth.

Principles of Service

Inclusion and Equity: Everyone has the right to comprehensive, equitable, and timely services. Each SA/DVTC will strive to identify and remove barriers hindering access to care.

Client-Centered: SA/DVTC services must be individualized, culturally safe, accessible, inclusive, trauma and violence-informed.

Informed Choice: Information must be delivered in a timely, accessible, and responsive way to facilitate a client's right to understand their care options and make informed choices.

Education: Professional development and ongoing education are key to delivering quality services by competent professionals.

Collaboration: Collaboration and networking to encourage information exchange, reduce isolation, and facilitate resource sharing.

Accountability: SA/DVTCs and professionals demonstrate accountability to both the individuals receiving our services and our funders through data reporting, program evaluation, and the delivery of quality, evidence-based services.

Trauma and Violence-Informed Services: Each SA/DVTC will provide trauma and violence-informed services.

Introduction

The Network has developed standards of care outlining evidence-based best practice guidelines which support standardization of service delivery expectations for all SA/DVTCs to provide the best health, psychosocial, and forensic care to all persons who have experienced sexual violence and/or domestic violence (intimate partner violence).

The following standards of care outline the knowledge, skills, and judgement needed by the health care professionals of each SA/DVTC program and establishes standardized indicators for care province wide. The practice points inform health care professionals of their accountabilities and the public of what to expect when engaging with an SA/DVTC.

This document, along with federal laws, provincial legislation and professional regulations, assists clinicians, programs, and hospital administrators to understand their responsibilities and to make safe and effective decisions in their program planning and clinical practice.

It is recognized that the health, psychosocial and forensic needs of children who have experienced sexual violence differ from those of adults.[1,2] Additionally, there are legislative differences, such as reporting obligations and considerations regarding consent.[1,2] Further information can be found in the ONSA/DVTC's Paediatric Standards of Care which have been developed for the pre-pubescent population.

To assist health care professionals to meet the expectations outlined in the following document, the Network provides a variety of educational opportunities for clinicians, including but not limited to: trauma therapy training, Sexual Assault Nurse Examiner (SANE) training, online paediatric peer review and educational sessions, HIV-PEP (Post Exposure Prophylaxis) training, a Clinical Education Forum, and up-to-date information, scientific research, and resources.

I. Organizational/Program Standards

Standard 1: SA/DVTC programs establish and promote a client-centered model of care. [2,3,4,5,6]

Indicators & Practice:

1. Every SA/DVTC develops policies and procedures to guide client care based on the philosophy and values of the Network.
2. Every SA/DVTC works in collaboration with other departments in the hospital to establish processes to expedite access to SA/DV care.

Standard 2: SA/DVTCs provide resources and supports to address the various factors that contribute to secondary traumatic stress and vicarious trauma in staff.[7]

Indicators & Practice:

1. Every SA/DVTC incorporates discussions about secondary traumatic stress and vicarious trauma and its impact during the recruitment of staff and in the orientation process.
2. Every SA/DVTC establishes processes to ensure both client and staff safety.
3. Every SA/DVTC provides staff with access to debriefing after cases.
4. Every SA/DVTC provides ongoing support for staff health promotion and self-care.
5. Every SA/DVTC commits to facilitating regular team meetings and access to ongoing training and education that are trauma-informed and include time designated to discuss secondary traumatic stress and vicarious trauma.
6. SA/DVTC clinicians are aware of Employee Assistance Programs (EAP), or other supports as needed.

Standard 3: SA/DVTC health care professionals providing care to survivors of sexual violence and/or domestic violence (intimate partner violence) are skilled and competent in this field.[2,5,6,8,9,10,11]

Indicators & Practice:

1. Health care professionals work within their scope of practice and in accordance with their hospital's medical directives/policies.
2. Health care professionals working in SA/DVTCs have completed specialized training in the areas of sexual violence and domestic violence (intimate partner violence).
3. Education and training must encompass the training requirements mandated by the Accessibility for Ontarians with Disabilities Act.
4. Education and training should include trauma and violence-informed care.
5. Education and training should include elements of cultural safety to address the specific needs of Ontario's diverse population.

6. Health care professionals demonstrate knowledge of the impacts of sexual violence and domestic violence (intimate partner violence) with a feminist and intersectional analysis across the lifespan.
7. Health care professionals demonstrate knowledge, skill, judgement, compassion, and empathy in their approach to care.
8. Health care professionals are supported to participate in ongoing professional development activities including but not limited to educational opportunities, case consultations, and peer review sessions to maintain competency and enhance skills.
9. Health care professionals are prepared for court testimony through court preparation which includes, chart review, meeting with the crown attorney in advance of the trial, and guidance from the team leader or designate (see guidance Recommendations for Supporting Clinicians when Subpoenaed to Testify in Court).

Standard 4: SA/DVTCs demonstrate respect for client autonomy.[3,4,5,6]

Indicators & Practice:

1. Clients are recognized as having unique and individual needs that are shaped by factors such as cultural identity, sexual orientation, age, gender, gender identity, gender expression, ability, socio-economic situation, religious beliefs, and social circumstances.
2. The health care professional provides the information and modifies communication style, as necessary, to meet the needs of the client to support informed decision making.
3. A certified, medically trained language interpreter for the client whose preferred language of communication may differ from that of the health care professional. Family members will not be used for language interpretation for medical care.
4. A certified interpreter [i.e. an American Sign Language (ASL) interpreter] is utilized for a client who is hearing impaired.
5. The client is the expert in determining their own needs; therefore, the client's decisions are honoured, respected, and supported.
6. A support person can accompany the client, if desired by the client and of the client's choosing, during the examination and any follow-up appointments.

Standard 5: SA/DVTCs recognize and address the unique needs of clients and ensure that the *Accessibility for Ontarians with Disabilities Act* customer service standards are implemented.[11]

Indicators & Practice:

1. Additional supports will be provided as necessary, including (but not limited to):
2. An accessible clinical space that increases the autonomy of clients with physical disabilities, including bathrooms and accessibility equipment such as the examination table, seating, and communication tools.

Standard 6: SA/DVTC health care professionals obtain informed consent from the client prior to the provision of health and forensic care.[12,13,14]

Indicators & Practice:

1. The health care professional obtains informed consent in accordance with the *Health Care Consent Act* which is reflected in the professional standards of the providers licensing body.
2. The health care professional provides comprehensive, non-biased information to clients regarding the care and forensic options available, including explanation of the unique purposes of forensic examinations, options of care, and alternate reporting options.
3. When the client is unable to provide informed consent for the collection of forensic evidence, due to either a temporary or permanent mental disability, change of cognitive status from their normal functioning or an altered level of consciousness, a decision algorithm may be utilized to determine the timing and process for the potential collection of forensic evidence (see *Guidelines for Care for the Person who is Unable to Provide Consent*).

Standard 7: The SA/DVTC works collaboratively with their organization's Health Information and Privacy departments to establish processes to maintain client confidentiality.[1,5,15,16,17,18,19,20,21]

Indicators & Practice:

1. The health care professional follows provincial legislation and organizational policies and procedures regarding client consent, confidentiality, privacy, storage/maintenance of records, and release of information.
2. The health care professional shares only pertinent information about the client with other healthcare providers directly involved in the client's care, unless the client has provided informed consent to the release of medical information.
3. The health care professional only collects information that is relevant and required for the provision of health, psychosocial, and forensic care related to the assault.
4. The health care professional ensures that clients understand the limits of confidentiality as outlined by law and professional standards. Specifically, relevant information pertaining to client safety and the safety of others must be shared with appropriate authorities if:
    a. There are reasonable grounds to suspect that a child under the age of 16 is residing in the home and is at risk of experiencing or witnessing harm (i.e., domestic violence).
    b. There are reasonable grounds to suspect that a child under the age of 16 is at ongoing risk of abuse, including sexual exploitation.
        i. *Note: Under the Child, Youth, and Family Services Act, youth under the age of 18 may enter into voluntary services agreements with child*

protection services. The duty to report does not extend to youth aged 16 and 17 years.

c. There are reasonable grounds to suspect that a client is at risk of harming themselves or others.
d. A client is being treated for a gunshot wound.
e. There is abuse perpetrated by a professional identified within the Regulated Health Professions Act within the context of care.
f. Abuse has occurred to a client living in a Long-Term Care Home or a Retirement Home.

5. The healthcare professional must ensure clients understand that health records are subject to a production order or warrant.

Standard 8: The SA/DVTC emergency service is provided with dedicated space within the hospital for the examination and care of victims/survivors of sexual violence and/or domestic violence. To meet the medical, forensic, and psychosocial needs of the victim/survivor and their support person(s), the following are recommended:

1. A private area in close proximity to other 24/7 services in case assistance is required.
2. A waiting area for police and support people.
3. Access to comfort measures.
4. Close proximity to an accessible bathroom that has a shower, ideally within the examination room itself.
5. Easy access to all the equipment required by the examiner, including (but not limited to): Sexual Assault Evidence Kits (SAEKs) and Auxiliary Kits, a digital camera, alternate light source, speculums, a refrigerator and freezer with a lock and temperature monitoring, a cupboard with a lock, clothing, linens, phlebotomy equipment, medications, and specimen collection tools.
6. Ensure established cleaning and infection control processes are followed.

II. Client Care Standards - Acute (Emergency) Service

The emergency service is generally considered for clients who present following a recent (acute) assault. For reporting purposes, "acute" has been defined as clients who present within 12 days of an assault. After 12 days post-assault and up to 30 days, clients are generally considered "non-acute" and may be seen either by a booked appointment or through the emergency service; individual SA/DVTCs will establish their own response protocols.

Client consent is obtained prior to the provision of services of the SA/DV program.

Standard 1: Care will be provided to the client in a timely manner.

Indicators & Practice:

1. The SA/DVTC health care professional will respond within 15 minutes of being requested and will attend to the client within 60 minutes (one hour).
    a. Exceptions to the one-hour response time may include, but are not limited to, urgent medical care for the client taking priority over the forensic/health care, the client is unable to provide consent, long travel time to a satellite site, and/or the health care professional attending to another client. If medically or forensically relevant, a delayed response time outlining the reason is documented in the client's chart.
2. The SA/DVTC program maintains the monthly Navigation Line schedule to ensure clients are appropriately navigated to service.
    a. If clients require redirection to another service to ensure timely assistance, processes are established among centres around the provision of care.

Standard 2: The safety, privacy and physical comfort needs of the client are addressed. [3,5,13,15,16]

Indicators & Practice:

1. Clients are provided a quiet, private treatment area with appropriate and accessible equipment that meet organizational standards.
2. Breaks are taken during care as requested by the client.
3. Treatment areas are situated within the organization with secure access (i.e., key card access, cameras, locked doors, alert alarms etc.) and organizational security measures are followed.

Standard 3: The health care professional provides crisis intervention that is trauma and violence-informed and culturally safe. [3,9,10,34,35]

Indicators & Practice:

1. The health care professional provides support that is nonjudgemental.
2. The health care professional identifies and focuses on client strengths and coping strategies.
3. The health care professional assesses the client and documents for suicidality, non-suicidal self-harm, and harm to others and seeks support as needed.
4. The health care professional seeks emergent mental health support as needed.
5. The health care professional has knowledge of community resources to offer referrals and provide additional support to the client.

Standard 4 (Health History Documentation): The health care professional completes and documents a comprehensive, developmentally appropriate client history, to assist in providing context for appropriate health and/or forensic care decisions.[22]

Indicators & Practice:

1. Health care professionals ensure client history includes:
   a) Relevant current and past medical history
   b) Allergies
   c) Current medications
   d) Immunization history
   e) Relevant reproductive history

Standard 5 (Physical Assessment): The health care professional completes and documents a focused head-to-toe physical assessment based on the reported health and assault history that is age, gender, developmentally, and culturally appropriate.[6,8,22]

Indicators & Practice:

1. Assessment and documentation include:
   a) Mental status (i.e., appearance, cognition, affect, behaviour, & speech).
   b) Subjective and objective data.
   c) Physical injuries related to the assault are accurately measured and described using body diagrams.
2. Prompt and appropriate medical care is provided for any identified injuries or medical needs as indicated.
3. The health care professional utilizes the documentation tools developed by the Network (or hospital approved adaptions of) to ensure documentation is thorough, complete, consistent, and relevant.
   a) Injuries are photographed, as per Acute (Emergency) Service Standard 11.

Standard 6: The client's health concerns about pregnancy are addressed.[23]

Indicators & Practice:

1. The risks of pregnancy are discussed with the client, taking into consideration assault history, client health history, and current contraceptive use.
2. When indicated, baseline diagnostic testing (urine or serum) is completed for clients who have female reproductive anatomy.
3. Clients are offered and provided emergency contraception for the prevention of pregnancy when indicated.
4. Clients are provided with information about their pregnancy status as well as their options regarding pregnancy status when indicated.

Standard 7: The client's health concerns about sexually transmitted infections (STIs) and sexually transmitted blood-borne infections (STBBIs) are addressed.[24]

Indicators & Practice:

1. The health care professional discusses the risk of exposure to STIs and STBBIs based on both assault history and other activities.
2. Following a discussion with the client and with their consent, the health care professional will provide screening for Chlamydia, Gonorrhea, Trichomoniasis, Human Immunodeficiency Virus (HIV), Syphilis, and Hepatitis B and C.
    a. STBBI testing is guided by the *Network's Guidelines for Medical/Healthcare for Clinicians at SA/DV Treatment Centres*.
3. The health care professional offers and provides medications and/or vaccinations as per the *Network's Guidelines for Medical/Healthcare for Clinicians at SA/DV Treatment Centres* and *Medical Guidelines for HIV Post Exposure Prophylaxis (HIV PEP) for Sexual Assault Victims/Survivors*.
    a. ***Note**: Consideration for Hepatitis A and HPV should be discussed with clients along with appropriate referrals*.

Standard 8: Drug Facilitated Assault (DFA) care is considered for all sexual assault and/or domestic violence clients.[23,24,25]

Indicators & Practice:

1. All clients who present to an SA/DVTC are screened for suspected Drug Facilitated Assault (DFA).
2. An additional DFA documentation form is used by the health care professional when DFA is disclosed, suspected, or unknown and further care/examination is required.
3. If the client cannot remember specific details of the assault, the health care professional may also use an Alternative Light Source (ALS) to assist in identifying

areas of both injury (ALS absorption) and forensic specimen collection (ALS fluorescence).

4. The health care professional offers and provides medications/vaccinations for the prevention of STIs and pregnancy, along with other care needed as a result of the suspected assault. See Acute (Emergency) Service Standards 6 and 7.
5. If DFA is suspected and the client has consented to the collection of a SAEK, all samples are collected as per the Centre of Forensic Sciences' (CFS) Hospital Instructions and either stored or released to police (with client consent).
6. External toxicology testing should be considered independent of the SAEK.
7. Where program resources and protocols permit, toxicology testing (independent of the SAEK) may be discussed and offered (if within timeframe) and sample(s) sent with client consent.

Standard 9: SA/DVTC programs provide competent, specialized forensic care to clients who have experienced sexual violence and/or domestic violence.[22,25,26,27]

Indicators & Practice:

1. Clients who have experienced sexual violence and/or domestic violence (intimate partner violence) are provided with a comprehensive explanation of the forensic options which may include:
    a. The collection of a SAEK, as designed by the CFS, to collect forensic evidence with appropriate history, up to and including, twelve (12) days post-sexual assault.
    b. Forensic evidence such as clothing, trace materials (i.e. fibers from wounds) and skin swabs are appropriately collected and documented (based on assault history).
    c. The storage of the SAEK as per SA/DVTC and CFS guidelines.
    d. Forensic documentation is completed using the forms provided in the SAEK and additional body diagrams where needed.
    e. The health care professional ensures that continuity of evidence is maintained throughout the evidence collection process, and the chain of custody is documented at each stage of evidence transfer.
    f. The health care professional ensures that procedures are followed to address contamination of evidence issues as per program protocol.
2. The health care professional will discuss with client the options to report to police, which include:
    a. Reporting the assault to police without the collection of forensic evidence.
    b. Reporting the assault to police with the collection and release of forensic evidence with written/signed consent.
    c. Reporting the assault to police with the collection and storage of forensic evidence.
    d. Where available, the option to provide an anonymous report of the assault to police is discussed and offered.

Standard 10: Clients are asked about non-fatal strangulation, smothering, and head injury during the assault and offered medical/forensic nursing care.[22,25,26,27]

Indicators & Practice:

1. The SA/DVTC health care professional utilizes the *ONSA/DVTC's Acute Non-Fatal Strangulation / Head Injury Assessment form*.
2. All findings are documented on the appropriate body maps and photographed (see Acute [Emergency] Service Standard 11).
3. Following CFS guidelines for collection:
    a. Skin swabs are obtained where the assailant may have touched the client's neck.
    b. Fingernail samples are obtained if the client scratched the assailant.
    c. Clothing is collected that has been damaged or has bodily fluids (i.e., blood).
4. ALS may also be used to assist in identifying areas of both injury (ALS absorption) and forensic specimen collection (ALS fluorescence).

Standard 11: Forensic photographs are taken following principles of forensic photography.[27,28]

Indicators & Practice:

1. Photographs are taken using a health focused assessment process and are part of the client's health/medical record, which also follow organizational Health Records Department release policies.
2. The forensic photos taken by the nurse are independent of photographs that may be taken by the police.
3. The photographs will be stored in a secure manner as per forensic photography standards and/or hospital and program protocol (i.e., on a protected drive or cloud).

Standard 12: All clients are assessed for the risk of ongoing violence and provided with safety planning strategies.[29]

Indicators & Practice:

1. A lethality assessment is completed [i.e., Danger Assessment-5 (DA-5)] and the client is offered an opportunity for a follow-up appointment for a full lethality assessment (Danger Assessment).
2. Safety planning is completed based on the client's needs and identified risks.

3. The development of a safety plan is documented, and a copy of the safety plan is provided to the client (if applicable).
4. Clients are informed about available community support services and provided information about those services in relation to further safety planning support (i.e., Victim Services, police).

Standard 13: All clients are offered follow-up medical, psychosocial, and forensic care.[8]

Indicators & Practice:

1. It will be determined if it is safe to contact the client, and if not, the client will be provided with contact numbers for the SA/DVTC.
2. Clients are informed about available community support services and provided information about those services.
3. As appropriate, the follow-up care plan is developed in conjunction with the client, their family, and/or others.

Standard 14: All clients are offered counselling as per program eligibility criteria.[5]

Indicators & Practice:

1. Counselling is offered either through the SA/DVTC program (i.e. in-house practitioners) or a community partner.
2. Counselling services should continue to be offered to clients who present through the acute service and who may initially decline.
3. Clients are provided information about available community support(s).

Standard 15: All clients are offered a written summary of the care received at the SA/DVTC program and any accepted follow-up care if safe to do so.[22]

Indicators & Practice:

1. The health care professional may utilize resources available from the Network (i.e., SA/DVTC Discharge Instructions, HIV PEP Booklets, Caring for Yourself Handout, Strangulation Discharge Instructions), which are available in multiple languages.
2. The discharge information may include:
    a. The name of nurse examiner and program contact information.
    b. Police service involved, if applicable.
    c. Any forensic care provided and if SAEK was stored at the hospital, the date when the evidence will be disposed.
    d. Medications/vaccinations provided and corresponding instructions, along with information regarding side effects and management of side effects.
    e. Any follow-up care recommended, along with the date and time of the follow-up appointment.

    f. Contact information for community agencies and crisis numbers.
3. Other documents that might be SA/DVTC specific (i.e. resources for support persons, safety planning booklets).

III. Client Care Standards - Follow-up Program

Standard 1: All clients who are seen in the acute (emergency) service are offered follow-up care to further address their medical, psychosocial, and forensic needs.[4,6,24]

Indicators & Practice:

1. Ideally clients are contacted within five business days of the initial visit to provide further support and assess for any additional needs.
2. Follow-up appointments can be provided in-person, virtually, or by telephone, based on client needs.
3. Risk assessment and safety planning will be offered again or reviewed with all clients on each visit.
4. Clients with injuries will be offered re-examination and to have re-documentation (including photos) completed.
5. Test results from the acute visit will be reviewed with the client.
6. The health care professional can offer testing for STIs and STBBIs, discusses medications and/or vaccinations as per program protocol and current Network's Guidelines for Medical/Healthcare for Clinicians at SA/DV Treatment Centres and Medical Guidelines for HIV Post Exposure Prophylaxis (HIV PEP) for Sexual Assault Victims/Survivors.
7. Any injuries requiring further medical attention will be referred to the most appropriate health care provider.
8. HIV Post-Exposure Prophylaxis (PEP) medication and follow-up care will be provided, at no cost.
    a. If needed, consultation with an infectious disease practitioner or HIV expert will occur.
9. Ongoing support and referrals will be provided as needed.

Standard 2: Clients may access follow-up services from another SA/DVTC.[3,12,15,22]

Indicators & Practice:

1. Clients will be provided the option to transfer their SA/DV care to another SA/DVTC in closest proximity to their current living situation.
2. The 'referring SA/DVTC' will obtain consent from the client to communicate with the 'receiving SA/DVTC' regarding the transfer of care will occur.
3. The client will be provided with the contact information of the 'receiving SA/DVTC' to where their care is being transferred.
4. The client will be provided with HIV PEP medication until they are able to arrange an appointment at the receiving SA/DVTC, to ensure uninterrupted treatment.
5. The 'referring SADVTC' will ensure treatment will be arranged, in coordination and collaboration with the receiving centre.

6. Results from any testing done at the ‘referring SA/DVTC’ will be communicated promptly to the client and the ‘receiving SA/DVTC’.

IV. Client Care Standards - Counselling Services

Standard 1: All clients seen through the acute (emergency) service of the SA/DVTC are prioritized to access confidential, trauma and violence-informed counselling at no cost to them (covered by MOHLTC) as it pertains to the mandate of the individual SA/DVTC. Clients who were not originally seen through the acute (emergency) service are also provided counselling depending on program resources. Family members may also be able to access limited counselling services to support the client.[1,5,17]

Indicators & Practice:

1. Clients are defined as adults and adolescents who have experienced sexual violence and/or domestic violence (intimate partner violence), and children who have experienced sexual abuse/assault. Centres that provide medical or counselling services to children and adolescents may also offer services to their non-offending caregivers.
2. Clients who request counselling services for sexual violence and/or domestic violence (intimate partner violence) are provided with or are referred to these services as soon as possible. All Centres will make every effort to provide counselling services in a timely manner.
3. During the first visit to the SA/DVTC, limitations to confidentiality including threats of harm to self or others as per the *Personal Health Information Protection Act* (s.40(1)) and the duty to report child protection concerns as per the *Child, Youth and Family Services Act*(s.125) are discussed.
4. The counselling service must furthermore ensure clients understand that counselling records may be subject to a production order or warrant.
5. Counselling services are provided in a culturally safe manner.

Standard 2: Clients who require support beyond the program scope and mandate will be referred to other resources for additional support.[5]

Indicators & Practice:

1. Clients will be informed of the scope of counselling services available and options for accessing community counselling services and resources.

Standard 3: A comprehensive clinical assessment will be conducted with all clients.[5]

Indicators & Practice:

1. Assessments are conducted in collaboration with the client. The counsellor is guided by feminist principles and intersectional analysis (as detailed in the Network's *Philosophy*, p. 5) and a solid knowledge base in trauma, sexual violence, and domestic violence (intimate partner violence).

2. Treatment goals and plans will be developed from this assessment in conjunction with the client.
3. As required, and in support of clinical work and the healing process, counsellors will advocate on behalf of clients within the various systems they may be engaged with (i.e., legal, housing, financial). This advocacy will be determined collaboratively between the counsellor and client.

Standard 4: All clients are assessed in the context of sexual violence and/or domestic violence experience. If needs are identified beyond the scope of trauma counselling and/or the mandate of the service, referrals will be made to appropriate community resources.[5]

Indicators & Practice:

1. Following a thorough assessment, issues outside the context of sexual violence and/or domestic violence (i.e., couples counselling, addiction treatment, historical trauma) will be referred to the appropriate service in the community.
2. Referrals will be discussed with the client and release of information consent forms will be signed where appropriate.
3. Counsellors will maintain a thorough knowledge of various services available in the community and form positive working relationships with these agencies.

Standard 5: Ongoing trauma counselling will follow a theoretically sound, clinically accepted, and evidence-informed approach.[5]

Indicators & Practice:

1. Counselling will be designed to create safety for the client. This may include providing clients and/or significant others (i.e., parents of children) with crisis intervention, psychoeducation, and support.
2. The modality of trauma treatment (i.e., Eye Movement Desensitization and Reprocessing, trauma-focused Dialectical Behavioral Therapy, etc.) will be decided by the counsellor in collaboration with the client based on the individual needs and preferences of the client, clinical judgment, and available evidence-based interventions.
3. Support groups and therapy groups may be offered to clients by counsellors. These groups may be co-facilitated by staff at local community agencies. Group practice will adhere to the same standards of individual practice.

Standard 6: Documentation will be completed in an appropriate and timely manner according to professional college and institutional guidelines.[5]

Indicators & Practice:

1. All pertinent information collected during the assessment will be documented with the use of a hospital-approved structured assessment form.
2. Assessment, treatment formulation, and recommendations, if indicated, will be documented in the counselling record.
3. Counsellors will maintain ongoing progress notes documenting the main issues addressed in each counselling session. Progress will be reviewed on a regular basis in relation to the treatment goals established and new goals will be developed as necessary.
4. Any referrals made to community agencies will be documented.
5. Clients will be informed of the possibility of their counselling records being subpoenaed if they are involved in court proceedings.
6. Steps will be taken to protect the highly sensitive and confidential information contained in clients' counselling records.
7. Counselling records will be maintained according to professional college and institutional guidelines.

Standard 7: Counsellors will maintain a commitment to professional development and a high standard of care.[5]

Indicators & Practice:

1. Counsellors will review the trauma and violence literature on a regular basis to ensure a relevant and current knowledge base and use of recognized clinical best practices.
2. Counsellors will participate in ongoing training, peer review, and other professional development activities, including but not limited to that provided by the Network.

V. Outreach and Education

Standard 1: SA/DVTC programs work in partnership with community agencies.

Indicators & Practice:

1. The SA/DVTC has local service agreements or MOUs with relevant allied community agencies to ensure that client referrals are appropriate and timely.
2. The SA/DVTC collaborates with community partners on issues relating to sexual assault and domestic violence (intimate partner violence).

Standard 2: The SA/DVTC program staff provide education to other health care professionals, community partners, and the general public to increase awareness of violence as a health issue.[4]

Indicators & Practice:

1. The SA/DVTC staff will participate regularly in community outreach/education events.
2. The SA/DVTC staff will be a resource and educator of hospital staff and the community on violence as a health issue and will provide educational sessions on a regular basis.

Standard 3: SA/DVTC programs participate in research opportunities to advance knowledge and practice.[19]

Indicators & Practice:

1. SA/DVTC programs participate in research initiatives undertaken by the Network.
2. SA/DVTC program staff follow established protocols as identified by the research initiative.
3. SA/DVTC programs engage in identifying research opportunities based on client/community needs to advance evidence-based best practice.

Standard 4: SA/DVTC programs actively enhance and maintain a community of practice.

Indicators & Practice:

1. SA/DVTC programs hold regular team meetings and opportunities for professional development (i.e., case consultations, peer review sessions).
2. SA/DVTC programs support clinicians to attend Network education opportunities (i.e., Clinical Education Forum).
3. SA/DVTC programs support clinicians to attend the Network's nursing and social work communities of practice.

4. SA/DVTC programs work in collaboration.
5. SA/DVTC Program Leaders attend Program Leader meetings.
6. SA/DVTC Program Leaders support Network activities as needed/requested (i.e., providing service statistics, timely feedback on projects/initiatives, etc.).
7. SA/DVTC Program Leaders collaborate with Network Regional Clinical Practice Leaders.

Glossary

Acute service
The acute (or emergency) service refers to care provided to clients who present within 12 days of an assault.

Children[1]
As per the *Child, Youth, and Family Services Act* "children" are defined as anyone under the age of 16.

Client/patient/individual/victim/survivor[3,4,]
Client: An individual, family, group, community or population receiving nursing care, including, but not limited to, "patients" or "residents."

We recognize the variance in how individuals who have experienced sexual violence and/or domestic violence self-identify, and as such the terms "client", "patient", "individual", "victim", and "survivor" are used interchangeably to describe persons accessing care and treatment at an SA/DVTC. Persons accessing care may include women, men, trans, and gender non-binary individuals across the lifespan.

Client-Centred Care[3,4]
In client-centred care, health care professionals consider clients' individual needs and preferences, and ensure clients are active participants in all aspects of their health care decisions.

Domestic Abuse/Violence[31]
"Domestic violence" or "intimate partner violence", can be defined as a pattern of behavior in any relationship that is used to gain or maintain power and control over an intimate partner. Abuse is physical, sexual, emotional, economic or psychological actions or threats of actions that influence another person. This includes any behaviors that frighten, intimidate, terrorize, manipulate, hurt, humiliate, blame, injure, or wound someone. Domestic abuse can happen to anyone of any race, age, sexual orientation, religion, or gender. It can occur within a range of relationships including couples who are married, living together or dating. Domestic violence affects people of all socioeconomic backgrounds and education levels.

Drug Facilitated Assault
Drug Facilitated Assault (DFA) occurs when someone is intoxicated with alcohol or substances they either knowingly or unknowingly consume. Drug Facilitated Assault encompasses both victims/survivors of sexual assault (DFSA) and victims/survivors of domestic violence (intimate partner violence).

Follow-up service

Follow-up service refers to ongoing (beyond acute) care provided to clients who require ongoing medical, psychosocial, and/or forensic care.

Non-acute service
Non-acute service refers to care provided to clients who present beyond 12 days of an assault.

Gender-Based Violence[32]
Violence based on gender norms and unequal power dynamics, perpetrated against someone based on their gender, gender expression, gender identity, or perceived gender. It takes many forms, including physical, economic, sexual, as well as emotional (psychological) abuse.

Sexual Violence[33]
According to the World Health Organization, sexual violence is "any sexual act, attempt to obtain a sexual act, or other act directed against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting."

In this document, we use the term "sexual violence" to represent the spectrum of violence that extends beyond the legal definition of "sexual assault", as defined in s.271-273 of the *Criminal Code of Canada.*[30]

Trauma and Violence-Informed Care[34,35]
An approach to engaging people with histories of trauma that recognizes the presence of trauma symptoms and acknowledges the role that trauma has played in their lives. Trauma is not only caused by single events that happen to an individual but also created by multiple and continuous forms of violence including 'systemic violence' of racism and social inequity.

Intersectional Analysis[36]
Intersectionality is a useful framework through which to examine how forms of privilege and disadvantage shape a victim's/survivor's experiences of trauma and access to resources. It acknowledges the social factors that contribute to gender-based violence and subsequent health. An intersectional lens can also improve the way services are organized and provided with attention to multiple forms of oppression and structural violence.

Vicarious Trauma[7]
The acute and cumulative impacts on individual staff and a team when working in high-stress, trauma-exposed environments, such as consistent exposure to stories of suffering. Working in such a context creates an increased risk for professionals to experience cognitive, emotional, behavioural, spiritual, interpersonal, and physical impacts of doing trauma-exposed work.

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For information about these Standards of Care or the Ontario Network of Sexual Assault/Domestic Violence Treatment Centres please visit our website www.sadvtreatmentcentres.ca or at 416-323-7327