STANDARDS OF CARE

SECOND EDITION
2019

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 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 2019 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 ("ONSADVTC" or "the Network") provides leadership and support to hospital-based Sexual Assault/Domestic Violence Treatment Centres (SA/DVTCs) across Ontario.

The goal of the Network team, which includes a Provincial Director, researchers, and education and outreach staff, is to support SA/DVTCs providing comprehensive, timely, trauma-informed care and trauma-specific treatment to victims/survivors of sexual violence and domestic violence which addresses their individual health, forensic, and psycho-social 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, physicians, and administrative staff. The Network works in collaboration with medical and legal professionals as well as community partners in raising awareness through education, 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-informed care to all persons (women, men, and trans individuals, across the lifespan) who have experienced sexual violence and/or domestic violence. Services may include: emergency medical and nursing care, testing and treatment of sexually transmitted infections (including HIV) and pregnancy prophylaxis or emergency contraception, crisis intervention, 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 analysis of violence which recognizes the embedded social, cultural, and systemic imbalances within society that promote and maintain violence. 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 psycho-social needs of those who have experienced sexual violence and/or domestic violence.

Mission

To provide leadership and support through advocacy, education, and research to 24/7, hospital-based Sexual Assault/Domestic Violence Treatment Centres across Ontario.

Mandate

The mandate of the Sexual Assault/Domestic Violence Treatment Centres is to address the health, psycho-social, and forensic needs of victims/survivors of sexual violence and/or domestic violence in a prompt, professional, and compassionate manner.

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, wide-spread, 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 who use violence against others need to be held accountable.
5. Sexual violence and domestic violence must be addressed collectively by the health care, legal, social, and political systems.
6. Everyone has the right to services to aid in their recovery.
7. Services must be accessible and staff appropriately trained to provide care to all community members.
8. Access to trauma-specific services can mitigate harm and facilitate healing and post-traumatic growth.

Principles of Service

Inclusion and Equity: Everyone has the right to effective, equitable, and timely, services.

Client-Centred: Our services must be individualized, culturally appropriate, accessible, consistent, sensitive, and non-judgmental.

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

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

Collaboration: Collaboration and networking 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 collection, program evaluation, and the delivery of quality, evidence-based services.

Trauma-Specific Services: Each SA/DVTC will provide trauma specific services. (See glossary for a definition of trauma-specific services)

Introduction

The Network has developed standards of care to establish a minimum standard of service delivery expectations so that all SA/DVTCs provide the best health, psycho-social, and forensic care to all persons who have experienced sexual violence and/or domestic violence.

The following standards of care outline the knowledge, skills, and judgment needed by the health care professionals of each SA/DVTC program and establish standardized expectations for care province wide. They inform health care professionals of their accountabilities and the public of what to expect when attending an SA/DVTC.

This document, along with federal and provincial laws 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, psycho-social, and forensic needs of children who have experienced sexual violence differ from those of adults. Additionally, there are legislative differences such as reporting obligations and considerations regarding consent. Further information can be found in the *Management of Acute Child and Adolescent Sexual Abuse and Assault*[1].

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 training, online pediatric peer review and educational sessions, HIV-PEP (Post Exposure Prophylaxis) training, an annual Clinical Education Forum, and a website with up-to-date information, scientific research, information, and resources.

I. Organizational/Program Standards

Standard 1: Health care facilities treating clients who have experienced sexual violence and/or domestic violence establish and promote a patient-centered model of care.[2, 3, 4]

Indicators & Practice:

- Every SA/DVTC develops policies and procedures to guide client care based on the philosophy and values of the Network.

Standard 2: SA/DVTC programs ensure that the health care professionals providing care to survivors of sexual violence and/or domestic violence are skilled and competent in this field.[5, 6, 7]

Indicators & Practice:

- SA/DVTCs utilize health care professionals who have received specialized training in the areas of sexual violence and domestic violence.
- Education and training should include training requirements under the *Accessibility for Ontarians with Disabilities Act*[8] and should incorporate cultural sensitivity components to recognize the unique needs of Ontario's diverse population.
- Health care professionals demonstrate knowledge of the impacts of sexual violence and domestic violence with a gendered lens and across the lifespan.
- Health care professionals demonstrate knowledge, skill, judgment, compassion, and empathy in their approach to care.
- Health care professionals are supported to participate in ongoing professional development activities including educational opportunities, case consultations, and peer review sessions to maintain skills and competency.

Standard 3: Respect for client autonomy.[2, 3, 4]

Indicators & Practice:

- Clients are recognized as having unique and individual needs that are influenced by their individual cultural identity, sexual orientation, age, gender identity, ability, socio-economic situation, religious beliefs, and social circumstance.
- The health care professional provides the information and education that is required for a client to make informed decisions.
- The client is the expert in determining their own needs, and therefore client decisions are respected and supported.

Standard 4: 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.[3, 8, 9]

Indicators & Practice:

- Additional supports will be provided as necessary, including (but not limited to):
    - A language interpreter for the client who speaks and understands a language different from the health care professional
    - An American Sign Language (ASL) interpreter for a client who is hearing impaired
    - An examination table that increases the autonomy of clients with physical disabilities
    - A support person if desired by the client and of the client's choosing during the examination and any follow-up appointments

Standard 5: Informed consent is obtained from the client prior to the provision of health and forensic care.[10, 11]

Indicators & Practice:

- The health care professional obtains consent in accordance with the *Health Care Consent Act*[12] which is reflected in professional standards.
- 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 medical and forensic examinations, material risks, material side effects, alternative courses of action, and likely consequences of not receiving treatment.
- When the client is unable to provide consent for the collection of forensic evidence due to permanent mental disability or an altered level of consciousness, a decision algorithm is 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 6: The institution and SA/DVTC maintain client confidentiality. [13, 14, 15]

Indicators & Practice:

- The health care professional shares only necessary information about clients with others who are in their direct circle of care unless the client has consented to the release of medical information.
- The health care professional only collects information that is relevant and required for the provision of health, psycho-social, and forensic care related to the assault.

- The health care professional ensures that clients understand the parameters 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:

    - There are reasonable grounds to suspect that a child under the age of 16 is residing in the home and is considered to be at risk of experiencing or witnessing harm.[16]
    - There are reasonable grounds to suspect that a child under the age of 16 is considered to be at ongoing risk of abuse.[15] *Note: Under the Child, Youth, and Family Services Act[15], youth under the age of 18 may enter into voluntary services agreements with a Children's Aid Society. The duty to report does not extend to youth aged 16 and 17 years.*
    - There are reasonable grounds to suspect that a client is considered to be at risk of harming themselves or others.[17]
    - A client is being treated for a gunshot wound.[18]

  The healthcare professional must furthermore ensure clients understand that health records are subject to subpoena.

Standard 7: 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. In order to meet the medical, forensic, and psycho-social needs of the victim/survivor and their support person(s), the following are required:

- A private area in close proximity to other 24/7 services in case assistance is required
- A waiting area for police and support persons
- Wheelchair access as well as an adjustable examination bed
- Close proximity to a bathroom that has a shower, ideally within the examination room itself
- All the equipment required by the examiner, including (but not limited to): Sexual Assault Evidence Kits (SAEKs), a refrigerator, a freezer, a cupboard with a lock, clothing, linens, venipuncture equipment, medications, and specimen collection tools
- Established cleaning protocols and procedures to ensure that there is no contamination of forensic evidence

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 those clients presenting within 12 days of an assault. After 12 days post-assault, clients can be seen either by a booked appointment or through the emergency service. After 12 days, clients are generally considered "non-acute" and individual SA/DVTCs will establish their own response protocols for these clients.

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

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

Indicators & Practice:

- The SA/DVTC health care professional will respond within 15 minutes of being paged and will attend to the client within one hour. Exceptions to the one-hour response time may include: medical care for the client taking priority over the forensic/health care, long travel time to a satellite site, and/or the health care professional attending to another client. Delayed response time outlining the reason is documented in the patient chart.

Standard 2: The safety, privacy, and physical comfort needs of the client are addressed.[14, 15]

Indicators & Practice:

- Clients are provided a quiet, private treatment area.
- Protocols are established between the Emergency Department and the SA/DVTC to expedite medical clearance.

Standard 3: The health care professional provides crisis intervention that is trauma-informed and culturally appropriate.[3, 4, 19]

Indicators & Practice:

- The health care professional provides support that is non-judgmental
- The health care professional identifies and focuses on strengths that the client possesses to manage the crisis.
- The health care professional assesses the client for suicidality and is able to articulate and differentiate between self-harm, suicide threat, and suicide attempt (without or without injury).
- The health care professional is able to identify and document protective and risk factors as related to suicide.

- The health care professional is able to identify the client's patterns of adaptive and maladaptive coping.
- The health care professional is able to assess the client's current coping skills and strategies, and discuss what is/is not working
- The health care professional is able to identify with the client what has worked in the past when encountering similar crises.
- The health care professional consults with the appropriate service/team member when clients are displaying maladaptive behaviors that would include suicide.
- The health care professional has knowledge of social support networks and community resources in support of psycho-social functioning.

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.[20]

Indicators & Practice:

- Health care professionals ensure client history includes:
  1) Relevant current and past medical history
  2) Allergies
  3) Current medications
  4) Vaccination status
  5) Contraception/barrier usage
  6) Last menstrual period (where appropriate)
- The health care professional utilizes the Sexual Assault (SA), Domestic Violence (DV), and Pediatric Sexual Assault documentation tools as developed by the Network (or close adaptions of) to ensure that documentation is thorough, complete, consistent, and relevant.
- Additional documentation may be completed using more in-depth body maps, photography, the Drug Facilitated Sexual Assault Addendum, the HIV Initial Assessment, and/or the Strangulation Assessment forms.
- Injuries are photographed, as per Standard 11, below.

Standard 5 (Physical Assessment): The health care professional completes and documents a relevant head to toe physical assessment based on the reported history that is age, gender, developmentally, and culturally appropriate. The client's medical needs resulting from the assault are subsequently addressed by the appropriate health care professional.

Indicators & Practice:

- Assessment and documentation may include:
  - Physical appearance, cognition, and mental status
  - Clothing and personal possessions

  - Anogenital structures
  - Sexual maturation
  - Physical injuries (i.e. blunt force, sharp force, gunshot wounds, strangulation) related to the assault accurately measured and described using body diagrams
- Medical intervention for injury or any urgent medical condition is provided by the emergency/urgent care department staff. The timing of the SA/DVTC team involvement in care is determined on a case-by-case basis.
- Health care professionals work within their scope of practice and in accordance with their hospital's medical directives/policies.

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

Indicators & Practice:

- When indicated, baseline diagnostic testing (urine or serum) for BHCG is obtained for all clients who have a potential for pregnancy.
- The risks of pregnancy from the assault are discussed with the client, taking into consideration assault history, client health history, and current contraceptive use.
- Clients are offered and provided emergency contraception for the prevention of pregnancy when indicated.

Standard 7: The client's health concerns about sexually transmitted infections (STIs) are addressed.

Indicators & Practice:

- The health care professional discusses the risk of exposure to STIs based on assault history.
- The health care professional offers baseline STI testing, as per program policies and procedures, based on the Canadian Public Health Agency Guidelines[21]. Testing includes areas of penetration or attempted penetration (vaginal, anus, urethra, mouth) based on assault history.
- The health care professional offers and provides medications/vaccinations for the prevention of Hepatitis B, Hepatitis A, and HIV, and testing and monitoring or testing and prophylactic/presumptive treatment for STIs such as Syphilis, Trichomoniasis, Gonorrhea and Chlamydia, as per program protocol and current standards as recommended by current guidelines.[21, 22]
  Note: consideration for HPV should be discussed with clients along with appropriate referrals.

Standard 8: Drug Facilitated Sexual Assault (DFSA) care is considered for all sexual assault clients.

Indicators & Practice:

- All sexual assault clients who present to an SA/DVTC are screened for suspected DFSA.
- Screening for DFSA is incorporated into the Network's Sexual Assault documentation tool.
- A supplemental DFSA documentation tool is used by the health care professional when DFSA is suspected and further care/examination is required.
- When the client is unable to recall details of the assault, the health care professional may utilize an alternative light source (ALS) examination, when available.
- The health care professional offers and provides medications/vaccinations for the prevention of STIs[21, 22] and pregnancy[23], along with other care needed as a result of the suspected assault. (See Standards 6 and 7.)
- If DFSA is suspected and the client is reporting to police, all samples in the Sexual Assault Evidence Kit (SAEK) are collected and stored or released to police (with client consent).
- Some clients are hesitant to report to police because of lack of memory about what happened. Others do not want to report but want to ascertain if drugging and sexual assault occurred. In these cases, and if available, the health care professional can offer the following:
    - The collection of a urine sample to be sent to a designated laboratory (e.g. Toxicology Unit, Sick Kids in Toronto) for analysis for the presence of drugs/alcohol. The collection and appropriate storage of the SAEK should be offered in conjunction with the above sample.

Standard 9: SA/DVTC programs provide competent, specialized forensic care to clients who have experienced sexual violence and/or domestic violence.[5, 6, 7]

Indicators & Practice:

- Clients are provided with a comprehensive explanation of the forensic options which may include:
    - The collection and release of forensic evidence to police with the consent of the client.
    - Documentation of injuries, including photo-documentation
    - The collection and storage of forensic evidence at the hospital pending the client's decision about reporting to police.
    - Reporting the assault to police without the collection of forensic evidence.
    - No forensic evidence collection and no report to police.
    - Anonymous report of the assault to police when available.

- For clients who have experienced sexual violence:
    - The Sexual Assault Evidence Kit (SAEK) as designed by the Centre of Forensic Sciences is used to collect forensic evidence with appropriate history up to twelve days post-sexual assault.
    - Forensic documentation is completed using the forms provided in the SAEK, as well as additional documentation tools (i.e., DFSA Addendum, Strangulation Assessment).
    - Photo-documentation and/or body-map diagrams of injuries are completed when applicable.
    - Continuity of evidence is maintained through the evidence collection process and the chain of custody is documented.
    - Procedures are followed to address contamination of evidence issues as per program protocol.

- For clients who have experienced domestic violence:
    - Forensic evidence such as clothing (and other items) is appropriately collected and documented (based on the history).
    - Forensic documentation is completed using the SA/DVTC Domestic Violence Documentation tool, Strangulation Assessment tool and/or SAEK as indicated.
    - Photo-documentation and body-map diagrams of injuries are completed when applicable.

Standard 10: Clients are screened for non-fatal strangulation and offered health/forensic nursing care including history taking, physical assessment, documentation of signs and symptoms and injuries, photo-documentation, and collection of skin swabs.

Indicators & Practice:

- All clients are asked if a non-fatal strangulation incident took place as part of the sexual assault and/or domestic violence incident.
- All clients who answer yes to having been strangled during a sexual assault or domestic violence incident are offered the options of care, and informed consent is obtained before proceeding.
- The healthcare professional utilizes the Network's Strangulation Assessment tool to collect a history of the non-fatal strangulation incident, and a focused physical exam is completed as outlined on the tool.
- All injuries are documented on body maps included in the Strangulation Assessment tool.
- All injuries and areas of tenderness are photographed, including photographs of the client's eyes. The body parts photographed are documented in the health record as per the forensic photography standard (Standard 11).

- Skin swabs are obtained where the assailant may have touched the neck.
- Fingernail samples may be collected if the client scratched the assailant.

Standard 11: All clients with injuries or those who have been strangled are offered the option of having forensic photographs taken. These are independent of photographs that may be taken by the police and are included in the health record and support the documentation of injuries.

Indicators & Practice:

- Injuries will be photographed following the general guidelines for forensic photography which include:
  - An identification page
  - A photograph of the client
  - An orientation photograph which shows the area of the body being photographed
  - Close-up photographs of each injury in the body area previously identified, with and without a forensic ruler
- 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). See *Scientific Working Group on Digital Evidence (SWGDE) Mobile Device Photography for Comparative Analysis Position Paper*.[24]

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

Indicators & Practice:

- Appropriate risk/lethality assessment tools are utilized, and their use documented.
- Documentation that a safety plan has been developed and provided to the client is recorded on the Sexual Assault Documentation form and/or Domestic Violence Documentation form.
- Transportation to a shelter or other place of safety is arranged.
- The safety plan includes phone numbers for 24-hour crisis lines, information and contact numbers for community agencies such as shelters, legal services, and police, as well as strategies to increase personal safety.

Standard 13: All clients are offered follow-up medical care at the SA/DVTC program. Referrals for counselling may be made to the SA/DV program or a community agency for ongoing support.[25, 26]

Indicators & Practice:

- All clients seen through the emergency service are offered continued care for ongoing medical forensic follow-up. Counselling is offered either through the SA/DVTC program or an appropriate community partner.
- The follow-up care offered to the client is recorded as part of the nursing documentation. It will be ascertained if it is safe to contact the client and if not, the client will be provided with contact numbers for the SA/DVTC.
- Clients are informed about available community support services and provided information about those services. As appropriate, the follow-up care plan is developed in conjunction with the client, their family, and/or others.
- Care is coordinated among the emergency service, counselling services, and follow-up support services to ensure timely access to care.

Standard 14: All clients are provided with written documentation of the care received at the SA/DVTC program and any accepted follow-up care. [20, 27]

Indicators & Practice:

- The information should be written clearly and at an appropriate level of language and include:
    - The name of nurse examiner and program contact information.
    - Any forensic care provided
    - Medications/vaccinations provided and corresponding instructions, along with information regarding side-effects and management of side effects
    - Follow-up care recommended, along with the date and time of the follow-up appointment
    - Contact information for community agencies
    - Safety planning
    - Risk/lethality assessment(s)

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, psycho-social, and forensic needs.[3, 4, 28]

Indicators & Practice:

- Follow-up appointments (in-person or via telephone) are arranged as the client chooses and corresponding to their medical, forensic and emotional needs, ideally within 2-4 days post-acute visit.
- Risk assessment and safety planning will be offered again or reviewed with all clients.
- Clients with injuries will (with consent) be re-examined and have injuries re-documented and photographed, ideally within 2-4 days post-acute visit when indicated.
- When indicated, test results from the acute visit will be reviewed with the client.
- HIV PEP medication and follow-up care will be provided, at no cost, for clients until they terminate the treatment, or the course of treatment is complete.
- If needed, consultation with an infectious disease or HIV expert will occur.
- SA clients will be informed re: Hepatitis B antigen and antibody status and the need for additional immunization as per STI treatment guidelines[21]
- Ongoing support and referrals will be provided as needed.

Standard 2: Client may access follow-up services from another SA/DVTC.[3, 10, 25]

Indicators & Practice:

- The client will be provided with the address, telephone number, and location of the site they choose to receive follow-up care at (known here as the 'receiving SA/DVTC').
- Medical release of information will be obtained from the client in order to send a copy of the hospital record from the initial SA/DVTC to the 'receiving SA/DVTC'.
- 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.

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-specific 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.

Indicators & Practice:

- Clients are defined as adults who have experienced sexual violence and/or domestic violence, and children and adolescents 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.
- Clients who request counselling services for sexual violence and/or domestic 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.
- 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*[17] [s.40(1)] and the duty to report child protection concerns as per the *Child, Youth and Family Services Act*[16] (s.125) are discussed.
- The counselling service must furthermore ensure clients understand that counselling records may be subject to a subpoena.
- Counselling services are provided in a culturally competent manner.

Standard 2: Clients who require support beyond the program scope and mandate will be referred to other resources for additional support.[4, 7]

Indicators & Practice:

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

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

Indicators & Practice:

- Assessments are conducted in collaboration with the client. The counsellor is guided by feminist principles (as detailed in the Network's *Philosophy*, found on p. 5) and a solid knowledge base in trauma, sexual violence, and domestic violence.
- Treatment goals and plans will be developed from this assessment in conjunction with the client.

- 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 (e.g., legal, housing, financial).

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.[4, 7]

Indicators & Practice:

- Following a thorough assessment, issues outside the context of sexual violence and/or domestic violence (e.g., couples counselling, addiction treatment) will be referred to the appropriate service in the community.
- Referrals will be discussed with the client and release of information consent forms will be signed where appropriate.
- 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.[7]

Indicators & Practice:

- Counselling will be designed to create safety for the client. This may include providing clients and/or significant others (e.g., parents of children) with crisis intervention, psychoeducation, and support.
- The modality of trauma treatment (e.g., Eye Movement Desensitization and Reprocessing, energy psychology, trauma-focused Cognitive 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.
- Support groups and therapy groups may be offered to clients by counsellors at an SA/DVTC. 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.[27]

Indicators & Practice:

- All pertinent information collected during the assessment will be documented with the use of a structured assessment form.

- Assessment, treatment formulation, and recommendations, if indicated, will be documented in the counselling record.
- 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.
- Any referrals made to community agencies will be documented.
- Clients will be informed of the possibility of their counselling records being subpoenaed if they are involved in court proceedings.
- Steps will be taken to protect the highly sensitive and confidential information contained in clients' counselling records.
- 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.[7]

Indicators & Practice:

- 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.
- Counsellors will participate in ongoing training, peer review, and other professional development activities, including but not limited to that provided by the Network.

V. Education and Outreach

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

Indicators & Practice:

- The SA/DVTC has local service agreements with relevant stakeholders to ensure that client referrals are appropriate and timely.
- The SA/DVTC staff participate on local community advisory committees relating to sexual assault and domestic violence.

Standard 2: The SA/DVTC program staff provide education to other health care professionals, community partners, and the general public in order to increase awareness of violence as a health issue.[3, 29]

Indicators & Practice:

- The SA/DVTC staff will participate regularly in community outreach/education events.
- 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.

Indicators & Practice:

- SA/DVTC programs participate in research initiatives undertaken by the Network
- SA/DVTC program staff follow established protocols as identified by the research initiative
- 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:

- SA/DVTC programs hold regular team meetings and opportunities for professional development (i.e. case consultations, peer review sessions)
- SA/DVTC programs support clinicians to attend Network education opportunities (i.e. Clinical Education Forum)
- SA/DVTC programs will be represented on the Network's nursing and social work committees.

- SA/DVTC Program Leaders will attend Program Leader meetings.
- SA/DVTC Program Leaders will support Network activities as needed/requested (i.e., providing service statistics, timely feedback on projects/initiatives, etc.).

Glossary

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

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

Client/victim/survivor
We recognize the variance in how individuals who have experienced sexual violence and/or domestic violence self-identify, and as such the terms "client", "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.

Domestic Violence
Domestic Violence, or intimate partner violence, involves one person asserting their power over another person in order to control or maintain control over them. What characterizes intimate partner violence is the ongoing effort to assert power and maintain control over one's partner. It often increases in frequency and intensity. The abuse can occur in intimate relationships regardless of gender and/or sexual identities. All persons can be survivors/victims of intimate partner violence. The violence can take many forms, including physical, emotional, sexual, intimidation/ psychological, spiritual, and financial abuse. Often, more than one of these forms of violence are used together, along with manipulation tactics that transfer responsibility for the abuse from the assailant to the victim/survivor.

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

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

Sexual Violence
Sexual violence is any form of sexual activity with another person without their consent. There are many forms of sexual violence, including but not limited to forced kissing, grabbing, fondling, sexual harassment, attempted or completed rape (vaginal, oral, or anal penetration by a sex organ, other body part, or foreign object), and forced participation in child exploitation/pornography.

Sexual violence is about power and control being asserted over another person. With sexual violence, a person's *right* to determine what happens with their own body, mind, and spirit is taken away.

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-informed

The Network adopts the following definition of trauma-informed:
"A program, organization, or system that is trauma-informed:

1. *Realizes* the widespread impact of trauma and understands potential paths for recovery;
2. *Recognizes* the signs and symptoms of trauma in clients, families, staff, and others involved with the system;
3. *Responds* by fully integrating knowledge about trauma into policies, procedures, and practices; and
4. *Seeks* to actively resist re-traumatization."

(Taken from *Trauma Informed Care in Behavioural Health Sciences: A Treatment Protocol*[31])

Trauma-specific

The term "trauma-specific services" refers to evidence-based and promising prevention, intervention, or treatment services that are designed specifically to address trauma responses and adaptations and facilitate healing in an integrated manner. Trauma-specific services must be provided in an environment in which trauma-informed practices have already been implemented. (Adapted from *Guidelines for Trauma-Informed Practice in Women's Substance use Services*[32] and *Trauma Informed Care in Behavioral Health Sciences: A Treatment Protocol*[31]).

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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 contact the Provincial Director, Ontario Network of SA/DVTCs at 416-323-6400 ext. 4472