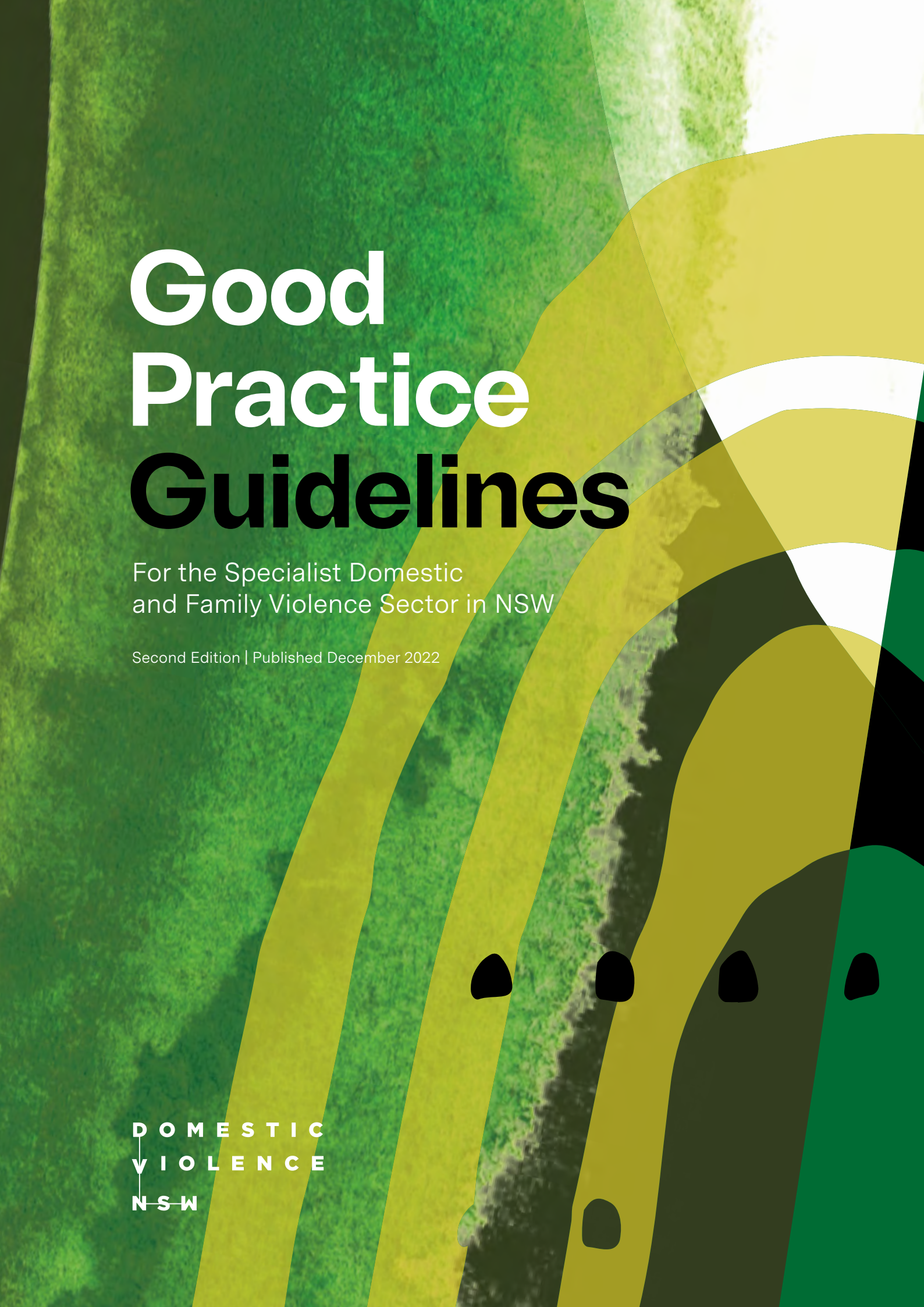

Good Practice Guidelines

For the Specialist Domestic and Family Violence Sector in NSW

Second Edition | Published December 2022

DOMESTIC VIOLENCE NSW

About Domestic Violence NSW

Domestic Violence NSW (DVNSW) is the peak body for specialist domestic and family violence services in New South Wales. DVNSW works from a feminist, social justice perspective and recognises that domestic and family violence is serious, prevalent, and driven by gender inequality. The goal of DVNSW is to eliminate all forms of domestic and family violence.

DVNSW works to improve the spectrum of policy, legislative and program responses to domestic and family violence (DFV) and to eliminate DFV through leadership in advocacy, partnerships and promoting best practice responses and primary prevention.

Our vision: Women, families and communities in NSW live free from violence, have equal rights, equal opportunities and the freedom to reach their potential.

Our purpose: DVNSW provides a representative and advocacy function for specialist services and the women, families and communities they support.

DOMESTIC VIOLENCE NSW

Recommended citation

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Disclaimer

The Good Practice Guidelines and the associated Principles and Practice Guidelines are written according to the evidence base, practice wisdom and best practice principles at the date of publication.

Compliance with the Good Practice Guidelines does not guarantee the safety, quality or acceptability of service provision nor ensure the compliance of a service or program with legislative, policy or funding obligations.

Domestic Violence NSW does not accept any liability for injury, loss or damage incurred by use of or reliance on the information included in this resource. Any copy of this resource not sourced directly from Domestic Violence NSW is considered uncontrolled.

Acknowledgements to the people and the land

Domestic Violence NSW's office is situated on Gadigal land in Redfern. We pay our respects to the Gadigal people of the Eora Nation and all Elders past, present and emerging.

We thank the traditional owners and original custodians of lands throughout NSW for their wisdom, guidance, and support to work on land that was never ceded. We acknowledge the disproportionately high rates of violence impacting Aboriginal and/or Torres Strait Islander women, families and communities. We acknowledge the ongoing impacts of colonisation and systemic racism that are still present within institutions and the broader community. We acknowledge that we work in the context of generations of resilient, strengths-based, holistic resistance to violence in Aboriginal and/or Torres Strait Islander communities.

Domestic Violence NSW strives to position ourselves as allies, to walk alongside, to listen, to give our voice and strength, to respect, to never forget and to learn from past mistakes so that we can actively support and promote the voices of Aboriginal people and organisations in all our work.

Acknowledgement of victim-survivors

Domestic Violence NSW honours the experiences, strength and courage of all victim-survivors of domestic and family violence and sexual violence. We recognise that responses to domestic and family violence must be informed by the voices and lived experience of victim-survivors. We acknowledge that many victim-survivors cannot safely speak out or are not heard. We remember those who did not survive and pay our respects to their friends and families.

Domestic Violence NSW acknowledges that adults, children and young people experience domestic, sexual and family violence, and that Aboriginal and/or Torres Strait Islander people, sexuality and gender diverse people, people with disability and people from culturally and linguistically diverse communities often experience higher rates of violence than the broader community.

We acknowledge, respect and include the advocacy of those with lived expertise of domestic, sexual and family violence, children and young people, Aboriginal and/or Torres Strait Islander people, lesbian, gay, bisexual, transgender, queer (or questioning), intersex and asexual (LGBTIQA+), people with disability and people from culturally and linguistically diverse communities in the work to end violence.

We acknowledge the commitment of our member organisations and frontline workers to ending violence and abuse in our community and honour their tireless work towards positive and meaningful change.

Contents

CEO message

I am pleased to present the second edition of the Good Practice Guidelines, a guide for the specialist domestic and family violence sector to provide high quality and consistent services to victim-survivors. First published by Domestic Violence NSW (DVNSW) in 2017, our understanding of domestic and family violence and how it is experienced across the community continues to be enhanced through lived expertise, member feedback, research, sector collaborations, government inquiries and service reviews.

An independent review of the first edition of the Good Practice Guidelines undertaken in 2019-20 found that the Good Practice Guidelines are a useful and well-respected tool and have had a positive impact on the sector. The review also identified amendments to further build on its strengths.

Responding to violence is challenging work for services and practitioners, who face high demand and provide vital support for victim-survivors. The aim of the Good Practice Guidelines was, and still is, to support positive outcomes for victim-survivors by providing a framework for good practice service design and delivery.

I am grateful to the membership of DVNSW and other stakeholders who contributed their time and expertise to the development of the first and second editions of the Good Practice Guidelines. We acknowledge the time and input of the practitioners, lived expertise advocates, networks and service representatives who participated in consultations and contributed their expertise to the development of this work across NSW.

We also thank our colleagues in the Industry Partnership (Homelessness NSW and Yfoundations) for their advice, collaboration, and expertise.

We are incredibly grateful to the frontline practitioners who met with us to contribute. We thank you for the time, energy and effort you put into your work every day to improve the lives of victim-survivors of domestic and family violence. Your expertise and guidance is appreciated.

We honour and recognise the victim-survivors, families and communities across NSW that have experienced domestic and family violence. Your voices are central to improving service responses and ending gender-based violence.

Thank you also to the NSW Department of Communities and Justice for funding this work through the State Peaks Program grant funding.

I would also like to acknowledge and thank Christina Jarron who worked closely with Domestic Violence NSW to redevelop the Good Practice Guidelines into the second edition we have today. Your knowledge, expertise and time to develop this content is hugely valued.

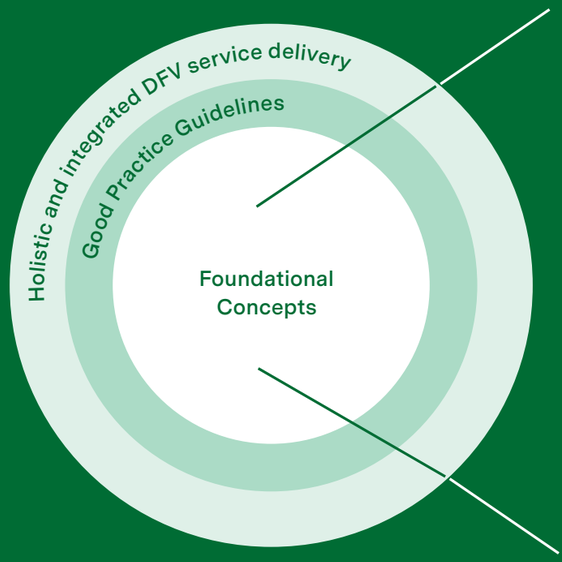
Finally, a huge thanks also to the incredible DVNSW team for your ongoing commitment and advocacy for the DFV sector and to Renata, Shelley, Sarah and Jasmine for all your work on developing this edition of the Guidelines.

The Guidelines edge us closer to achieving our vision that women (cis and trans), families and communities in NSW live free from violence, have equal rights, equal opportunities and the freedom to reach their potential.

Delia Donovan

The Good Practice Guidelines at a glance

The Good Practice Guidelines are built on foundational concepts listed below that have been developed by specialist family violence services and researchers over decades.



- Understanding DFV as a gendered issue
- Intersectional feminism
- Cultural safety
- Victim-survivor centred practice and empowerment
- Trauma and gendered-violence-informed approach
- Human rights
- Social justice
- Child-aware and Parent-sensitive practice

Principle		Practice Guidelines
	Principle 1: Safety and wellbeing	Threats to the safety of victim-survivors including children are identified and responded to effectively.
		The safety hazards of practitioners and others are identified and responded to effectively.
	Principle 2: Access and equity	Services are culturally safe, responsive and appropriate to the diverse needs and experiences of victim-survivors, including children.
		Practitioners have a thorough understanding of the diversity and intersectionality's of victim-survivor experiences and are culturally safe and responsive.
		Services are accessible and prominent in the community.
		Services provide culturally safe and appropriate practice for Aboriginal and/or Torres Strait Islander victim-survivors to be supported and guided.
	Principle 3: Domestic and family violence (DFV)-informed and trauma-informed specialist practice	Services are committed to working in a DFV-informed and trauma-informed way that aligns with a strengths-based framework.
		Services address the impacts of vicarious trauma on staff.
	Principle 4: Victim-survivor centred practice and empowerment	The service partners with victim-survivors to ensure they are at the centre of all decisions relating to them.
		The service works from an empowering, person-centred and strengths-based framework that is child-aware and parent-sensitive, and practitioners treat all victim-survivors with respect, dignity, sensitivity and equality.
		The service recognises children and young people as active contributors and clients in their own right.
	Principle 5: Confidentiality and informed consent	Victim-survivors have their right to confidentiality and privacy respected and are informed of situations where their right to confidentiality may be limited.
		Victim-survivors have a right to access their data.
		The service meets ethical and legal obligations in relation to confidentiality and privacy. The service also has secure record-keeping procedures and informs victim-survivors of these procedures.
	Principle 6: Non-judgemental support	Services support, listen to, and respond to victim-survivors in a respectful, dignified, sensitive and non-judgemental way.
		Practitioners provide safe, non-judgemental and inclusive surroundings.
	Principle 7: Collaboration	Services are committed to actively engaging with the local service ecology and improving the outcomes of victim-survivors, including children, through coordination, collaboration and integration that provides continuity of care.
	Principle 8: Upholding and advocating for victim-survivor rights	Services and practitioners advance the rights and interests of victim-survivors at an individual level in a victim-survivor centred manner that is culturally safe.
		Services acknowledge systemic issues and work to influence policy and legislation to uphold the rights of, and improve responses to, victim-survivors of DFV and those at risk.
	Principle 9: Prevention	Services participate in activities that tackle the drivers of DFV and promote perpetrator accountability for violence prevention.
	Principle 10: Competency, accountability and continuous improvement	Practitioners have the skills and training to work effectively with victim-survivors of DFV.
		Services demonstrate accountability to victim-survivors by monitoring, evaluating and continuously improving practice.
		Services support practitioners by providing a positive and empowering work environment, training and inducting new staff, and embedding practices for professional development.
		The organisation has strong governance which delivers sustainable accountable, transparent and responsive services in addition to ensuring legislative, regulatory and funding compliance.

1. Key terms and definitions

Domestic and family violence
Domestic violence is when someone behaves abusively towards a person they are in or have been in an intimate relationship with. Family violence refers to violence perpetrated by a family member, chosen family member or person from a kinship relationship or family relationship with. Domestic and family violence (DFV) is part of a pattern of behaviour that controls or dominates a person and makes them fear for their own and/or other people's safety and wellbeing. DFV includes, but is not limited to physical violence, sexual violence, verbal abuse, emotional abuse, psychological abuse and economic abuse. DFV is an overarching term that includes other related terms such as intimate partner violence, elder abuse, child abuse and adolescent family violence.

Intersectional approaches
Intersectional approaches involve recognising that an experience can differ based on cultural, individual, historical, environmental, or structural factors such as race, age, geographic location, sexual orientation, ability or class. This approach also recognises that dynamics of oppression and inequalities can be confounded by other forms of oppression and inequality, resulting in some groups of people experiencing more severe forms of violence and face even more barriers to support their safety. [1]

Lived expertise
Lived expertise refers to the specific and contextual expertise that comes from lived experience of abuse and violence. Victim-survivors have intimate, firsthand knowledge of the context of DFV, services, systems and structures that may have supported them or failed to support them. Working with those who have lived expertise is essential to informing appropriate and effective initiatives.[2]

Strengths-based practice
A practice that focuses on abilities, knowledge, and capacities of the client rather than deficits or things they may be lacking. This involves using client-led goals, focussing on strengths, facilitating support and growth, valuing difference and collaboration, and providing hope and motivation.[3]

Trauma-informed practice
Trauma-informed care and practice recognises the prevalence of trauma and its impacts on the emotional, psychological and social well-being of people and communities. Trauma-informed practice means integrating an understanding of past and current experiences of violence and trauma in all aspects of service delivery. The goal of trauma-informed systems is to avoid re-traumatising individuals and support safety, choice and control to promote healing.[4]

Victim-survivors
Many people who have experienced DFV and sexual violence may refer to themselves differently; as survivors, as victims, as people who have experienced violence. It is important that services and practitioners use the term chosen by their clients. Within these Guidelines the term victim-survivor is used to encompass those identities. This term is also inclusive of children who have experienced, witnessed or been exposed to the effects of DFV, including infants, toddlers and children.

Further definitions and terms are provided in the glossary.

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[1] Department of Social Services, 2022
[2] Department of Social Services, 2022
[3] Department of Social Services, 2022
[4] Department of Social Services, 2022

2. Introduction

Domestic and family violence (DFV) work is complex, nuanced and requires specialist responses. The serious and widespread nature of DFV in Australia places significant pressure on responding services.

Victim-survivors seeking assistance require access to quality service provision delivered by appropriately skilled practitioners that is tailored to their needs and inclusive of people regardless of socio-economic status, culture, spirituality, ability, sexuality, gender or location.

Practitioners require appropriate and ongoing training to ensure they can practice to a high standard and feel supported, empowered and strengthened in their daily work.

Services need guidance on high quality service provision that is best practice within the specialist domestic and family violence sector.

In the absence of quality service delivery standards in NSW, the Good Practice Guidelines aim to define the specialist work of the domestic and family violence sector to ensure consistency and quality in service responses within and between regions in NSW.

The Good Practice Guidelines are built on and reinforce theory, practices and procedures that have developed over decades of expertise by experienced specialist domestic and family violence services alongside the latest evidence on good practice.

In 2016, DVNSW began consultation with the specialist DFV sector to develop the first edition of the Good Practice Guidelines. This was developed over 18 months, beginning with a literature and evidence review exploring models and practice guidelines operating in other jurisdictions. DVNSW conducted extensive consultation with DFV practitioners working in NSW communities.

The Good Practice Guidelines were independently reviewed in 2019-20. With insights from a desktop review, online survey and consultations with DFV services, the review found that the Good Practice Guidelines were a well-regarded and useful resource.

The review made a series of recommendations that, together with insights from DVNSW members and developments in the evidence base and policy environment, have informed the second edition.

The second edition has been updated to include:

- Embedding intersectional approaches to quality DFV service provision
- Streamlining the Good Practice Guidelines to be easier to use and implement, including case studies to illustrate how DFV services can use the Good Practice Guidelines
- Offering examples for both practitioners and services under each principle.

Further information on the domestic and family violence policy context for the Good Practice Guidelines, additional good practice guides developed by the NSW Specialist Homelessness Services (SHS) Industry Partnership, a comparison with Australian Service Excellence Standards (ASES) accreditation and a summary of practice standards across other jurisdictions can be found under Practice Standards and the Policy Context - NSW and Australia. (Page 96).

There are two key sections to the Good Practice Guidelines:

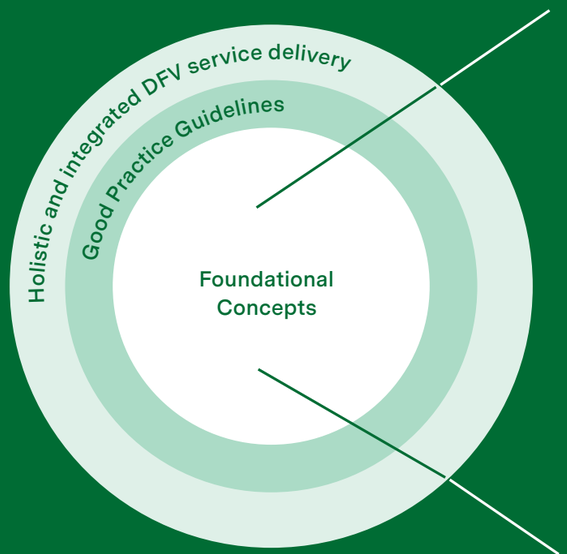
Good Practice Guidelines: this document provides direction to services and individuals working in the DFV sector in NSW on the fundamental concepts for effective service delivery to victim-survivors of DFV, and 10 principles for good practice. Each principle is separated into guidance for individual practitioners and for services.

An Online Resource Toolkit: regularly updated with policies, templates, and models of practice to help services meet the Good Practice Guidelines and work towards improving practice.

3. Foundational concepts

At the core of the Good Practice Guidelines are foundational concepts recognised by specialist domestic and family violence services and researchers over decades of quality service practice.

The relationships between the foundational concepts demonstrate the holistic and integrated nature of specialist DFV service delivery:



- Understanding DFV as a gendered issue
- Intersectional feminism
- Cultural safety
- Victim-survivor centred practice and empowerment
- Trauma and gendered-violence-informed approach
- Human rights
- Social justice
- Child-aware and Parent-sensitive practice

3.1 Understanding DFV as a gendered issue

Domestic and family violence (DFV) is gendered; the majority of intimate partner and family violence is perpetrated by men against women (cis and trans), and women are most likely to be the victim-survivors.

Gender of victim-survivors

- Women are nearly three times more likely than men to have experienced intimate partner violence.[5]
- Of NSW Aboriginal victim-survivors of DFV assault, at least 70% are female and of these, 16% are under the age of 18.[6]
- LGBTIQA+ people experience violence within intimate partner relationships at similar rates to cisgender heterosexual women (60.7% reported ever experiencing intimate partner violence (IPV), 64.9% reported ever experiencing family violence). The findings show the rates of sexual assault were highest among cisgender women, trans men and non–binary people.[7]
- The Private Lives 3 report highlighted that more than half of non-binary participants experienced verbal harassment from an intimate partner followed by 45.9% of trans men, 43.2% of cisgender women, 41.9% of trans women and 36.6% of cisgender men.[8]
- 1 in 4 (25%) of women with disability have experienced sexual violence after the age of 15, compared with 15% (or 978,000) with 1 in 14 (6.6%) men with disability.[9]

Perpetration of violence

Regardless of the gender of the victim-survivor, nearly all experience violence from a male perpetrator (95% of male victims and 94% of female victims).[10]

- For LGBTIQA+ victim-survivors, the gender of the perpetrator of sexual assault, tended to be a cisgender man 84.3%.[11]

DFV is a cause and consequence of gender inequality.[12] Research has identified a driver between gender inequality and DFV, and this is the foundation for Change the Story, a national approach to preventing men's violence against women coordinated through Our Watch.[13]

Gender inequality occurs when different genders are given unequal value and there is an unequal distribution of power, resources and opportunity between them.[14] Gender inequality is rooted in laws and policies that constrain the rights and opportunities of women and gender diverse people and is reinforced and maintained informally through social norms, practices and structures.[15]

These norms and structures encourage people to adopt distinct gender identities and stereotyped gender roles. This occurs within a hierarchy that historically positions men as superior to women and people of other genders, and masculine roles and identities as superior to feminine ones. To reduce gendered violence, historically entrenched beliefs must be challenged, along with the social, political and economic structures, practices and systems that support violence.

[5] Australian Bureau of Statistics, 2016
[6] NSW Bureau of Crime, Statistics and Research (BOCSAR), 2022
[7] Hill et al., 2020
[8] Hill et al., 2020
[9] Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, 2021
[10] Diemar, 2015, p.6. Note: survey did not include other gender expressions
[11] Hill et. al, 2020
[12] Jahan, 2018
[13] See, for example: United Nations, 2020; Heise & Kotsadam, 2015; Our Watch, 2021b
[14] Our Watch, 2021a
[15] Our Watch, 2021a

DFV service design, practice and policy needs to consistently take into account the effects of systemic and individual misogyny, sexism and denigration on victim-survivor safety, as well as the intersections with other forms of discrimination including racism and ableism. Gender safety is a crucial component of quality service provision that DFV services provide to facilitate growth, healing, wellness, and empowerment and must be at the core of practice.

Understanding the gendered nature of violence against LGBTIQA+ people

The drivers of violence against LGBTIQA+ people are gendered and are closely linked to the drivers of men's violence against cisgender women. The drivers of violence against LGBTIQA+ people are heteronormativity, and the rigid gender norms enabled through these social structures. Cisgenderism is a form of structural oppression that denies, denigrates and pathologises non-cisgender identities and expressions. Heteronormativity is the perspective that sees heterosexuality as the only, preferred or 'normal' sexuality. Individuals and communities who are not heterosexual and whose gender does not fit within the binary are policed and punished.

Cisgenderism and heteronormativity don't just drive violence against LGBTIQA+ people- they are forces which punish anyone who steps outside of rigid ideas of what 'men' and 'women' should be. Challenging cisgenderism and heteronormativity can therefore help to prevent violence against LGBTIQA+ people of all genders, and all women.

Forced marriage

Forced marriage is a human rights abuse, a form of gender-based violence, and a form of modern slavery. When involving children, it is a form of child abuse.

Under Australian law, a forced marriage happens when one or both parties are married (under law or religious or cultural ceremony), without freely and fully consenting because of threats, coercion or deception. This includes when a person does not understand the nature and effect of a marriage, due to their mental capacity or age. In Australia, all marriages involving a child under 16 years of age are illegal and considered a forced marriage, regardless of whether there is 'consent'.

We know that there is substantial overlap between DFV and forced marriage, including significant parallels between their drivers and impacts. This includes the abuse commonly experienced within forced marriages, as well as people who do not feel free to leave a marriage, and who risk harm if they do. Some entities and organisations, including the New South Wales, Victorian and South Australian Governments, have come to recognise the practice of forced marriage itself as a form of DFV.

It is important to note that the legal definition of forced marriage only concerns the time of the marriage and does not capture the full experience of people affected. There is a growing recognition that people affected can experience a broader continuum of coercion and abuse, both before and after a forced marriage – and that those affected should be supported holistically, and at all stages. Coercive behaviour such as emotional, physical, and psychological abuse can begin before a forced marriage takes place, and often co-occurs with other forms of abuse such as family and honour-based violence. Once a forced marriage takes place, a person may continue to experience coercion and abuse such as being prevented from ending or leaving the marriage, family and domestic violence and other forms of modern slavery such as forced labour or domestic servitude.

3.2 Intersectional feminism

An intersectional approach recognises that victim-survivors of DFV and sexual violence experience multiple forms of inequality and acknowledges that a holistic understanding of these intersections, and their roots in power, privilege and oppression, is critical to effectively supporting victim-survivors.[16]

Intersectional feminism (also described here as 'intersectional approach' or 'intersectionality') is fundamental to good practice for DFV services. An intersectional approach recognises that gender inequality is not the only or most prominent factor in every experience of DFV; patriarchal and structural inequalities produce many other intersecting forms of oppression.[17] Victim-survivors often experience other forms of inequality and discrimination, such as ableism, ageism, classism, cisgenderism, heteronormativity, and racism that have contributed to their experience of gendered violence and prevent or limit them from exercising power, seeking or continuing support, accessing resources or participating in society.[18]

Victim-survivors may experience some or many of these forms of oppression. A victim-survivor's association with a social identity that experiences these forms of oppression may change over time. Listening to how the victim-survivor understands and experiences their identities and contexts is critical to an intersectional approach.[19]

Intersectionality is fundamentally an analysis of power and, DFV services need to maintain this focus. Misapplying intersectionality to focus only on the victim-survivor's identity can reinforce harmful and stigmatising assumptions that identity factors are responsible for victim-survivor experiences of DFV.[20] Understanding victim-survivor experiences as the outcome of intersecting structural oppressions and inequalities is fundamental to intersectional practice in DFV.

DFV services can take an intersectional approach to:[21]

- **Expand their understanding of DFV** to consider the role that power, privilege and oppression plays in people's experiences of DFV.
- **Build partnerships and collaborations** with specialist services to offer more inclusive and effective DFV services to marginalised groups.
- **Engage in reflective practice** at the service and practitioner levels to highlight how power dynamics inform service delivery and prevent victim-survivors accessing support and safety.
- **Review service design and delivery** to be more accessible, inclusive, culturally-safe, non-judgemental and informed by lived expertise.

[16] Steinmetz, 2020
[17] Domestic Violence Victoria, 2020
[18] Domestic Violence Victoria, 2020; Our Watch, 2021b
[19] Domestic Violence Victoria, 2020
[20] Domestic Violence Victoria, 2020
[21] Domestic Violence Victoria, 2020; Our Watch, 2021b

Emergence of intersectional feminism

There is a long history of Black feminists speaking out about how Black women's experiences differ from White women and Black men and identifying the interlocking systems of oppression that create this distinction.[22]

In 1989, American Black feminist activist and scholar Kimberlé Crenshaw named the operation of these systems 'intersectionality'. While Crenshaw focused on the intersections of race and gender, she explained that this highlighted the need to account for how multiple aspects of identity shape people's experiences, including how victim-survivors experience violence.[23]

3.3 Cultural safety

Each individual's cultural group/belonging has the capacity to influence the way in which a person has experienced trauma and violence and can be central to healing. Culture refers to a person's beliefs, customs and the predominant attitudes that characterise a particular group. For culture to play a role in recovery from traumatic experiences, DFV services must be culturally safe and inclusive. This includes being inclusive of people from various cultural backgrounds, genders, sexualities and identities.

Health services are increasingly recognising the link between health, recovery and connection to culture.[24] Cultural safety is:

an environment that is spiritually, socially and emotionally safe, as well as physically safe for people; where there is no assault, challenge or denial of their identity, of who they are and what they need. It is about shared respect, shared meaning, shared knowledge and experience, of learning together with dignity and truly listening.[25]

Cultural safety goes beyond cultural awareness or cultural competence; it requires a service and its practitioners to reflect and consider their own cultural identity, attitudes and beliefs and the impact these have on professional practice.[26] By practitioners considering their own map of the world, they can address their own unintended biases or prejudices. This is closely linked and vital for the effective operationalisation of all the foundational concepts. Service providers and practitioners need to practice self-reflection as part of withdrawing their own biases and beliefs.

"Even though non-Aboriginal professionals may try to walk in our shoes, it's still their own feet they are feeling." Horvane[27]

Meaningful collaboration between DFV services and other community organisations are critical to ensuring the cultural safety of DFV services and practitioners. Culturally safe approaches empower cultural identity, knowledge and tradition and involving those affected is integral to maintaining this safety. To ensure this, preserving respect, shared meaning, knowledge, and learning, living and working together with dignity and true listening is essential.[28] Cultural safety requires the environment and staff of a service to reflect the diversity of service users.

To deliver services in a culturally safe manner, there is a need for services and individual practitioners to understand how the convergence of historical and contemporary injustices shape the lives of Aboriginal and/or Torres Strait islander communities and other marginalised communities. In consultations for the revised Good Practice Guidelines, the DVNSW Aboriginal and Torres Strait Islander Steering Committee described culturally safe collaboration as including and accepting constructive and negative feedback; acknowledging the time and knowledge that partners contribute (often pro-bono); and resourcing the collaboration when possible.

All services should work with, make space for, and raise the voices of Aboriginal Community-Controlled Organisations. It is important for non-Aboriginal services not to compete with Aboriginal Services but to work side by side with them collaboratively. It is also important for Aboriginal women to have the power of choice – as not all Aboriginal women will choose to engage with Aboriginal services. Aboriginal victim-survivors attend mainstream services so it is essential that they are culturally safe and accessible.

3.4 Victim-survivor centred practice and empowerment

Every person is entitled to be treated with dignity and respect and be supported to make their own informed decisions. Victim-survivor centric service provision is culturally safe and prioritises centring and respecting how victim-survivors and community members define safety for themselves.[29]

Victim-survivor centred practice acknowledges that every experience of violence is unique and responses to disclosure of violence must be tailored to the needs, context, experiences and choices of the victim-survivor, without overwhelming them. Robust victim-survivor centred practice builds the confidence of victim-survivors to engage with services to support and guide their recovery.[30]

A perpetrator's abuse and controlling tactics can negatively impact a victim-survivor's sense of autonomy and personal power.[31] DFV services counter this through empowerment as a work practice. Empowerment is a process of supporting and educating victim-survivors to increase confidence and restore dignity and control over their lives, rather than taking a position of power by determining decisions and/or outcomes for the victim-survivor.[32] This approach is about partnering with the victim-survivor in an equal and collaborative way that supports decision-making.

This approach considers who the person is as a victim-survivor inclusive of their unique experiences, identities, perspectives, strengths, hopes and needs.[33] It is closely connected with other foundational concepts, in particular intersectionality, cultural safety and trauma-informed approaches.

This foundational concept highlights how every service response to a victim-survivor must be built around the needs and context of the individual and their children rather than a programmatic or predetermined service offer or practice model. Services and practitioners must operate from a position of listening, believing, and drawing on the strengths and resources of the victim-survivor.

[22] Ochefu, 2021
[23] Crenshaw, 1991
[24] Verbunt et al., 2021
[25] Williams, no date
[26] ANROWS, 2018
[27] Horvane 2012,p.31
[28] Department of Health VIC, 2021
[29] ANROWS, 2018
[30] Our Watch, 2021; Sen, 2019
[31] Domestic Violence Victoria, 2020
[32] Domestic Violence Victoria, 2020
[33] Domestic Violence Victoria, 2020

3.5 Trauma-informed approach

Trauma-informed services ensure that every aspect of the service, including management and program delivery systems, are assessed and modified to include a responsiveness to how trauma impacts on the life of those seeking support and the practitioners delivering the care.[34]

DFV is a traumatic experience: it creates a sense of fear and helplessness and can be overwhelming for victim-survivors to cope with. This may compromise physical and emotional safety and can profoundly impact thoughts, beliefs and behaviours.[35] Additionally, DFV can affect children by altering their relationship with parents and their emotions, behaviours, routines, communication and support networks.[36]

Violence and abuse can often have severe, pervasive and lifelong effects on both the victim-survivor and their child's physical, social and emotional health and wellbeing, identity, relationships, expectations of themselves and others, emotional regulation and world view.[37]

Trauma-informed approaches are person-centred, strengths-based and respond to the impact of trauma:

> '[trauma informed practice] is grounded in an understanding of and responsiveness to the impact of trauma, that physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment'.[38]

The Good Practice Guidelines reflect the key principles of trauma-informed approaches identified by Substance Abuse and Mental Health Services Administration (SAMHSA) and reflected in other foundational concepts:[39]

- Safety
- Trustworthiness and transparency
- Peer support
- Collaboration and mutuality
- Empowerment, voice and choice
- Cultural, historical, race and gender issues

These principles also help ensure a service does no further harm by retraumatisting a victim-survivor by stepping into a place of control or disempowerment.

3.6 Human rights

All human beings have the right to life, bodily integrity and a sense of dignity and respect irrespective of gender. Domestic and family violence and sexual violence is acknowledged as a violation of human rights across the world.[40]

International human rights instruments and legislation recognise this, including:

- The Universal Declaration of Human Rights, which states that no one shall be subject to torture or to cruel, inhuman or degrading treatment of punishment.[41]
- Convention on the Elimination of All Forms of Discrimination Against Women 1979 (CEDAW)
- Declaration on the Elimination of Violence Against Women 1993
- Convention on the Rights of the Child 1989
- Convention of the Rights of Persons with Disabilities

By adopting a human rights approach, services support victim-survivors to restore their human rights to live a life free from violence, with bodily integrity, dignity, and respect.[42]

[34] Atkinson, 2013
[35] Hopper, Bassuk, and Olivet, 2010; Blue Knot Foundation, no date
[36] Emerging Minds, 2021
[37] Elliott et al., 2005
[38] Hopper, Bassuk and Olivet, 2010
[39] Centre for Disease Control and Prevention, 2020
[40] United Nations, 1948
[41] United Nations, 1948
[42] United Nations, 1948

3.7 Social justice

Social justice values of equity, equality, access and participation are paramount to good practice DFV service provision.

A social justice framework requires the recognition and promotion of human rights, fairness in distribution of resources, and provision of services essential to meet people's basic needs and to improve victim-survivors quality of life. DFV services use a social justice framework through service provision and advocacy work.

A social justice framework for working with individuals and communities impacted by DFV requires consistent promotion of inclusivity, diversity and the fostering of environments that include and accept people so they have true and better opportunities for genuine participation and consultation about decisions affecting their lives.

3.8 Child-aware and parent-sensitive practice

A child-aware approach acknowledges and considers the experiences of children and young people and ensures children and young people are visible in all conversations.

It incorporates the role of those children in the client's life, whether or not working with children is part of the practitioner's scope of practice.

A child-inclusive approach involves children and young people in conversations about what is happening for them, and their social and emotional wellbeing, where it is appropriate to do so.

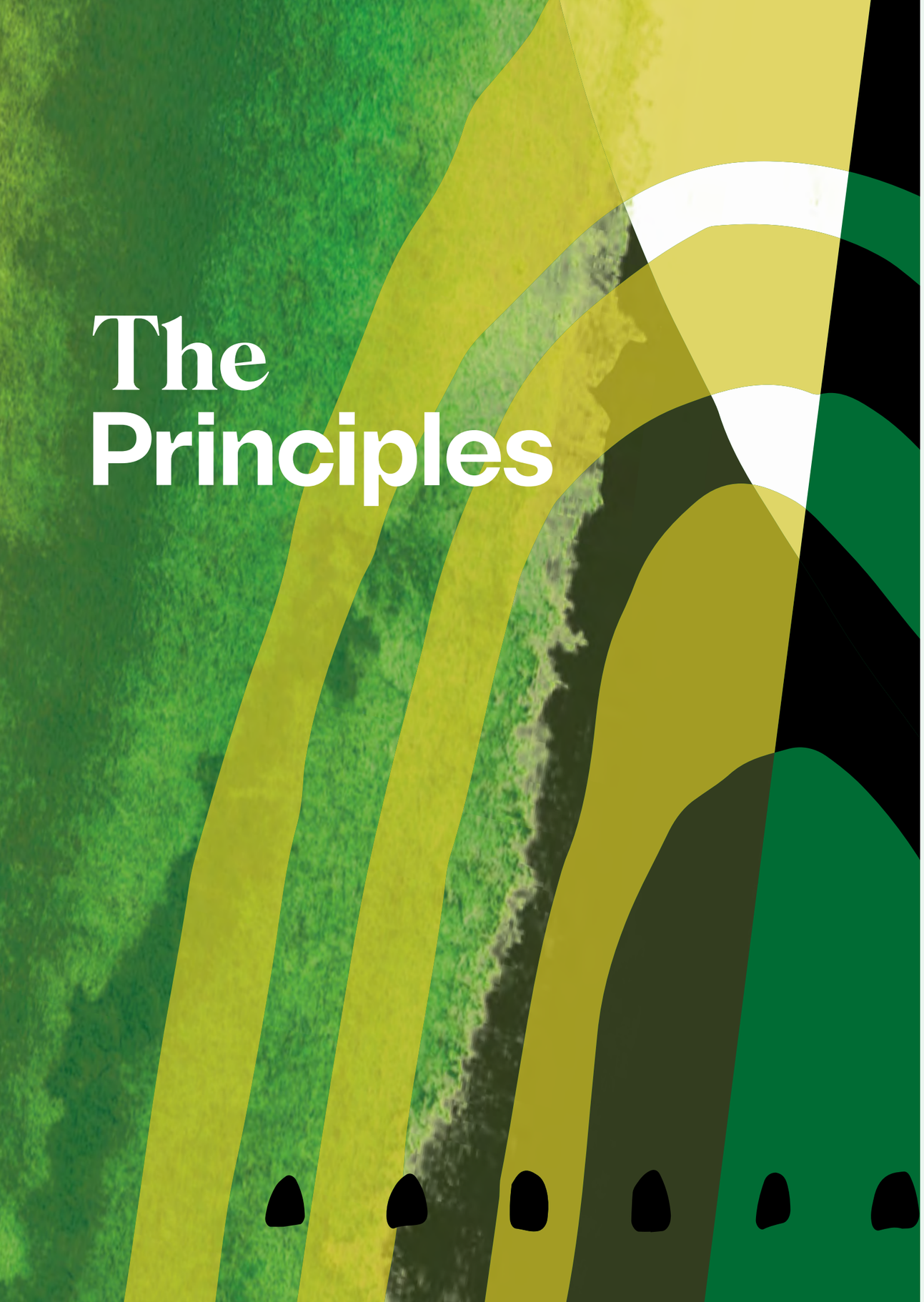
In the context of DFV, a parent-sensitive approach assumes that children's safety and their social and emotional wellbeing are of central importance for parents.

It sees the parenting role as a central feature of meaning and motivation in the client's life. Mothers who experience violence often feel a great sense of shame regarding the impacts of violence on their children with children often feeling shame too, which may impair their ability to seek help. For parents who do not have care of their children, their identity as parents should be considered and respected. A parent-sensitive approach finds ways to have conversations about the impact of violence on children and young people, without reinforcing stigma or shame.

In working with parents who perpetrate family violence, a parent-sensitive approach finds ways to have conversations with them about their children, their children's safety, and the effects of their violence on their children's wellbeing, without stigmatising or shaming.

This excerpt taken from "Family and Domestic Violence and Child-Aware Practice" course – Emerging Minds.

[43] Grearly et al., 2008



The Principles

The Good Practice Guidelines are based on ten core principles.

Principle 1:
Safety and wellbeing

Principle 2:
Access and equity

Principle 3:
Domestic and family violence-informed and trauma-informed specialist practice

Principle 4:
Victim-survivor centred practice and empowerment

Principle 5:
Confidentiality and informed consent

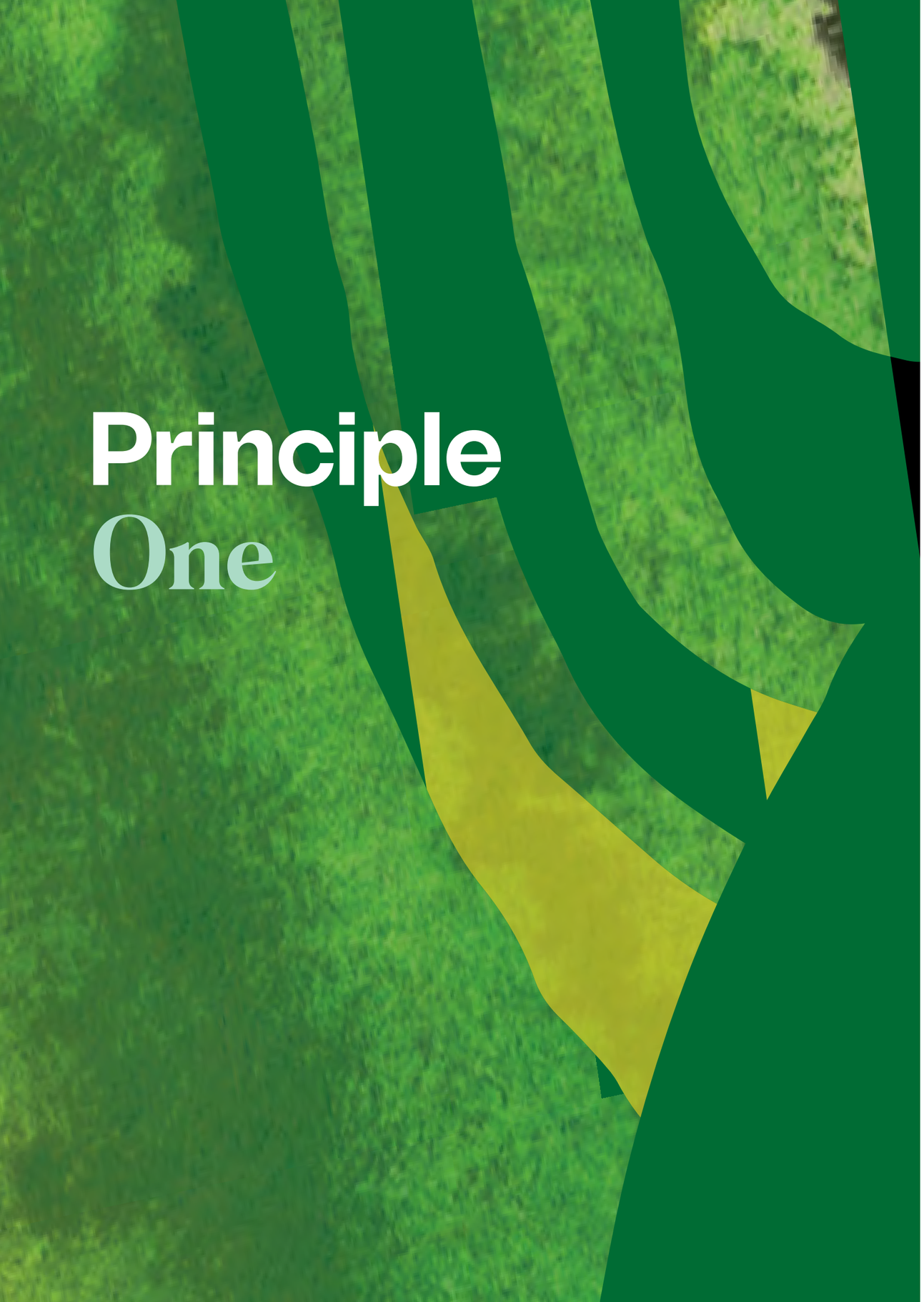
Principle 6:
Non-judgemental support

Principle 7:
Collaboration

Principle 8:
Upholding and advocating for victim-survivor rights

Principle 9:
Prevention

Principle 10:
Competency, accountability and continuous improvement



Principle 1: Safety and wellbeing

- Threats to the safety of victim-survivors including children are identified and responded to effectively.
- The safety hazards of practitioners and others are identified and responded to effectively.

The safety and wellbeing of victim-survivors of violence, and their children, and practitioners is the paramount consideration in any response to domestic and family violence. Safety and wellbeing are the cornerstones of trauma-informed practice.[44] Support services must listen to victim-survivor's assessment of risk as they know the risks posed by the individual perpetrators best.

Victim-survivor safety and wellbeing

Victim-survivors are often in crisis when engaging with DFV services and may have immediate safety concerns. Services must have the skills and expertise to respond in a flexible, efficient and coordinated way.[45]

Risk assessment and safety planning

Services must have comprehensive DFV risk assessment and safety planning processes to identify potential safety risks posed by the perpetrator/s of the violence and to assess the safety needs of victim-survivors (including children as clients in their own right).

The assessment of the impact of domestic and family violence and associated case work and safety planning specifically considers the age and developmental capacities and needs of each child and young person, including infants, very young children, primary school aged children, and adolescents.

Risk assessment and safety planning should only be carried out by trained professionals.

The difference between risk assessment and safety planning

Risk assessment is a process practitioners use to assess the level of threat a victim-survivor is facing. The NSW Government has endorsed the use of the Domestic Violence Safety Assessment Tool (DVSAT) which is being reviewed at the time of publication. It is a tool that considers the victim-survivor's experiences and self-assessed risk, information from other professionals and the professional judgement of the practitioner to determine risk. Victoria's Multi-Agency Risk Assessment and Management (MARAM) also support services to identify, assess and manage DFV risk. No To Violence also have the Risk Safety and Support Framework (RSSF) which is a guide for responding to men who use DFV and is designed to increase the safety of adult and children victim-survivors.

Safety planning is a process where the practitioner guides the DFV victim-survivor to consider their situation and to assess what practical measures they could implement to feel and be safer. These measures are often written down in a safety plan document and kept somewhere safe and protected. Services need to develop clear and comprehensive safety plans for each individual. This includes working with children as clients and understanding and responding to risks to their safety. There is no standard safety plan tool or template used across NSW as resources to assist services to develop their own safety planning tools.

[44] Domestic Violence Victoria 2020; Putt, Holder & O'Leary 2017
[45] Domestic Violence Victoria 2020

Research indicates that victim-survivors are experts in their own safety based on their experience with the perpetrator.[46] Victim-survivors often already have an informal safety plan or various actions they take to increase their safety prior to their engagement with a service (although they often don't refer to this as a safety plan) and the role of the practitioner is to use this expertise as the basis for risk assessment and safety planning. This includes understanding that children may also be actively involved within their own safety management and even that of their siblings and parents.

Partnering with victim-survivors to map the perpetrator's pattern of coercive control and actions taken to harm victim-survivors, including children, can show the range of DFV behaviours impacting the family and also the victim-survivor's strengths in keeping themselves and their children safe. The Safe and Together Institute provides a model and training on partnering with the victim-survivor and mapping perpetrator behaviour to manage risk.

Safety planning must account for the safety and security of victim-survivors, including children, within different service contexts and transition points – for example, when a victim-survivor enters crisis accommodation, when they are at court, and when supported by a service within their own home. Safety planning must take into consideration contemporary evidence about risk factors such as heightened risk at the time of separation. Maintaining an evidence informed approach to risk assessment and safety planning may enhance victim-survivors' decision making about the relationship and survival tactics. Additionally, this must be ongoing and regularly reviewed to account for any increased risks or changes in circumstances. When and how often this occurs will vary and be informed by changing circumstances of the victim-survivor and/or the perpetrator, the victim-survivor's changing assessment of risk and their safety needs, as well as the professional judgement of practitioners.

Practitioners can also formalise safety plans and support sharing this with other services by documenting safety plans to effectively enhance collaboration with partner agencies as they can demonstrate the proactive protective tactics victim-survivors are engaging as well as the impact the DFV behaviours are having on the family's life.

Sharing information across agencies can build a stronger picture of victim-survivor safety and the risks posed by perpetrators. There are various legal mechanisms in NSW which enable information sharing where there is a significant risk of harm present. Safety Action Meetings run by Women's Domestic Violence Court Advocacy Services and Police are an effective way of sharing information across agencies.

Duty of care

Service providers and practitioners have a duty of care to protect and promote the wellbeing of victim-survivors and their children by acting with reasonable care and skill. This is the standard of care and skill that would be expected of an ordinary, sensible person, in the same profession and same circumstances. Services and practitioners should have a thorough understanding of their duty of care requirements and ensure compliance. When working with victim-survivors with a disability its important services/practitioners assume capacity for informed decision-making unless otherwise informed by evidence from a trained practitioner. It is essential that workers uphold the human and legal rights of clients with disability in the least restricted manner possible. The right to informed decision making underpinned by the principles of dignity of risk should be discussed in relation to person with disability.

The management of identified risks to the victim-survivor and/or their family must be supported by policies and procedures that provide a basis for consistent, equitable, transparent and quality assessment and management processes. Safety must be prioritised with practitioners and services fulfilling their duty of care to victim-survivors and their children, practitioners and others. This includes meeting legislative responsibilities, for example, mandatory reporting responsibilities for children at risk of significant harm[47], and for children this includes collaboration and advocacy with their education environments.

Gender safety

Gender safety is a crucial component of quality service provision. In practice, this takes many forms including: offering sanitary items free of charge; providing a non-judgemental environment to discuss sexual health and making female counsellors, translators and other human service or health providers available for victim-survivors who have a gender preference for practitioners.

Services must be safe and affirming for trans women who access the service as victim-survivors. Ensuring this safety can involve partnerships with LGBTIQA+ specialist organisations, accessing training, and reviewing policies for inclusive language. Although there is a need for gender specific services, to ensure gender safety, services should also consider whether they can offer their services to be LGBTIQA+ inclusive.

Cultural safety

Practicing cultural safety can mean the difference between someone accessing or continuing with a service, or disconnecting and feeling like they aren't being heard. Culturally safe care is responsive to a client's cultural, linguistic and religious identity (see Foundational Concepts on page 18). DFV practitioners must not stereotype victim-survivors when considering how their culture, language and/or faith may impact on their care.[48] Members of culturally, linguistically and religiously diverse communities have varied experiences based on factors such as whether they are first or second-generation migrants, whether they are refugees and their visa status.[49] Victim-survivor centred care that considers the individual experiences of victim-survivors is core to culturally safe care.

DFV services need to reflect on organisational policies and procedures to understand if they reinforce or perpetuate intersecting forms of oppression, such as heterosexism and racism.

Practitioner safety and wellbeing

Services must manage the risk of workplace violence toward practitioners, clients and others according to government standards and as required under service contracts. This includes responding to immediate threats to safety and preventing and responding to longer-term threats to practitioner safety and wellbeing such as vicarious trauma and burnout. For more guidance on practitioner safety and wellbeing, refer to Principle 3 and Principle 10.

[46] Family Safety Victoria, 2019; Toivonen and Backhouse, 2018; Domestic Violence Victoria, 2020

[47] In NSW, mandatory reporting is regulated by the Children and Young Persons (Care and Protection) Act 1988

[48] Muslim Women Australia 2021

[49] Muslim Women Australia 2021

Guideline 1.1:

Threats to the safety of victim-survivors including children are identified and responded to effectively.

To align with this practice guideline, the service should:	To align with this practice guideline, the practitioner should:
Have values and/or a mission that aligns with principles relating to victim-survivor safety.	Assist victim-survivors, including children, if they want to develop a thorough safety plan that is regularly updated and revised to reflect changes in risk and circumstances. This must be survivor-led and can include: · Arranging/referring safe accommodation for the victim-survivor, including children. · Assisting the victim-survivor to obtain an Apprehended Domestic Violence Order This includes seeking to understand the adult victim-survivor's perspective on Police assistance and actively supporting them to overcome barriers to accessing Police or other assistance. · Obtaining additional security measures for the victim-survivor or their property. · Support the victim-survivor throughout the process of accessing legal protection/court support through direct service provision or partnership arrangements. · Identify safe, trusted relationship/s for children within their education environment to support their safety and wellbeing where relevant.
Have a risk assessment process at intake, during the case management process and on exit from the service to identify potential safety risks and assess the safety of the victim-survivor/s, including children.	Regularly revisit the safety and wellbeing of the victim-survivor through case planning and management, with separate case plans for children where appropriate.
Have intake and assessment processes that are inclusive of asking about client's parental status to identify potential risks for infants and children including ways to strengthen the parent-child relationship. This is especially important where infants and children are not visible to the service.	Always keep the location of a victim-survivor confidential and protected.
Include child-focused risk and safety planning that specifically considers times that the infant, child or young person will be in contact with the perpetrator (e.g. when violence is building or imminent at home / contact following separation) and considers different forms of technology that the child / parent uses.	Develop a needs/risk assessment and information gathering to identify victim-survivor's protective strengths and perpetrator patterns of behaviour as parenting choices, tying the impact of the perpetrator's behaviours to the child's safety, wellbeing and functioning as the source of concern (not the victim-survivor's choices).
When in person, provide victim-survivors a space that offers privacy, is gender safe, is culturally safe and has interview rooms to ensure confidentiality and security.	
When working remotely (i.e. phone or online), develop protocols such as code words or code sentences to accurately identify the victim-survivor and ensure they are able to talk.	
Have procedures in place for when the location of a victim-survivor is disclosed to someone that may impact on the safety of the victim-survivor.	
Maintain effective relationships with local police to reduce barriers to reporting DFV.	
Maintain effective relationships with local DCJ offices to support adult and child safety and wellbeing.	

Guideline 1.2:

The safety hazards of practitioners and others are identified and responded to effectively.

To align with this practice guideline, the service should:	To align with this practice guideline, the practitioner should:
Have policies and procedures in place to support the identification of threats to safety, the mitigation or elimination of threats to safety, emergency responses and critical incidents. This includes: · Securely storing the personal details of practitioners and not disclosing them. · Providing a work car so that practitioners are able to safely undertake outreach work and work within the community. · Providing all staff with safety training, the impacts of vicarious trauma and the importance of self-care. · Providing staff with immediate access to support and supervision to guide responses to identified threats to safety. · Giving staff access to debriefing, vicarious trauma and support mechanisms on an ongoing basis, particularly in relation to critical incidents. · Organising staff access to communication/ electronic response systems to maximise their safety e.g. duress alarms and/or mobile phones with emergency contact details.	Understand the link between safety and confidentiality, ensuring that the location of a service and clients is not disclosed purposefully or inadvertently.
Have a system to monitor the safety and whereabouts of staff that take into account geographic areas with poor internet/mobile phone coverage (i.e. sign in/out board, shared calendars).	Adhere to public health and safety guidelines when doing outreach work.
	Always keep the location of a victim-survivor confidential and protected.
	Develop a needs/risk assessment and information gathering to identify victim-survivor's protective strengths and perpetrator patterns of behaviour as parenting choices, tying the impact of the perpetrator's behaviours to the child's safety, wellbeing and functioning as the source of concern (not the victim-survivor's choices).

Online Resource Toolkit: Principle 1

Principle Two

Principle 2: Access and equity

- **Services are culturally safe, responsive and appropriate to the diverse needs and experiences of victim-survivors, including children.**
- **Practitioners have a thorough understanding of the diversity and intersectionality's of victim-survivor experiences and are culturally safe and responsive.**
- **Services are accessible and prominent in the community.**
- **Services provide culturally safe and appropriate practice for Aboriginal and/or Torres Strait Islander victim-survivors to be supported and guided.**

DVNSW acknowledge funding constraints which can limit the accessibility of services.

DFV services have a legal and ethical responsibility to provide accessible, responsive and appropriate support to the diverse range of victim-survivors, including children, in NSW. All victim-survivors have the right to easily access equitable, inclusive, culturally safe services, and to have their individual experiences, beliefs and choices respected. This is not only from a human rights perspective but is necessary to address the disproportionate impacts of family violence across population groups and the intersecting experiences of marginalisation, discrimination and oppression.[50]

Accessible and equitable services offer a warm and welcoming environment that helps victim-survivors, including children, from a range of backgrounds feel safe and accepted. This includes priority populations including Aboriginal and/or Torres Strait Islander women, women and/or children with disabilities, women from migrant and refugee backgrounds, and trans or gender diverse people.

To further prevent discrimination, specialist services must ensure their service considers their service design, eligibility criteria and practice approaches that respond to all individuals and their diverse communities. If any service needs to limit their eligibility criteria, evidence must justify and determine if it satisfies the criteria for an exemption under the Anti-Discrimination Act 1977 (NSW).[51]

Services working to good practice will go beyond legislative requirements to ensure accessible and equitable service provision and proactively prevent discrimination. Strategies to support this include: organisational policies on equal opportunity; Disability Action Plans and accessibility audits; Reconciliation Action Plans; participation in the Pride in Health and Wellbeing and/or the Australian Workplace Equality Index and a commitment to applying an intersectional feminist lens to service design and work practice, including reflective practice.

***SHS providers** should note the alignment between this principle and ASES Principles:*

- *Valuing people and diversity*
- *Social, environmental and ethical responsibility*

[50] Domestic Violence Victoria, 2020
[51] Anti-Discrimination Act 1977 No.48
[52] Domestic Violence Victoria, 2020

Integrated and specialised service provision in faith-based communities

Gender based violence occurs across all communities. Blaming DFV on religion or culture is harmful and perpetuates stereotypes about culturally diverse communities.

People from migrant and refugee backgrounds and faith-based communities face multiple structural barriers in seeking help for DFV and sexual violence. Integrated and specialised service provision is critical to ensuring access to DFV services for victim-survivors from these communities. To support these victim-survivors, DFV services need to have strong referral procedures in place with settlement services, legal service providers and support agencies.[53]

In some communities, religious leaders are involved in relationships and structures of care. In addition to supporting victim-survivors from migrant and refugee backgrounds and faith-based communities to access formal supports funded or authorised by government, DFV services also need to support victim-survivors to access informal processes that are customary or religious and community-based.[54]

[53] inTouch Multicultural Centre Against Family Violence, 2010

[54] Muslim Women Australia 2021

Guideline 2.1:
Services are culturally safe, responsive and appropriate to the diverse needs and experiences of victim-survivors, including children.

To align with this practice guideline, the service should:

Be free of charge or consider the victim-survivor's ability to pay and not discriminate or prohibit assistance to clients with no or limited income.	Have policies and procedures for working with clients living with cognitive and intellectual disabilities drawing on resources such as the WWILD How to Hear Me Resource Kit.
Facilitate external and internal supervision to support reflective practice on how the service and its practitioners may create/maintain barriers to access for victim-survivors.	Informational content is available in easy read for people with intellectual disability or cognitive disability, and policy and procedures should reflect meeting the needs of people with disability, including children and young people.
Assist and support victim-survivors who have no access to income and work collaboratively with other services to support their needs, including housing and financial support.	Have policies and procedures for intake and assessment that use culturally safe language and that reference the TransHub service provider intake form and ACON sexuality and gender indicators to ensure correct gender and pronoun usage.
Not apply blanket exclusions to service eligibility other than those related to the documented function of the service (e.g. a cis-man is seeking access to a women's refuge); recognising that some fluidity may be needed to address safety concerns.	Have appropriate policies on supports provided for sexuality and gender diverse clients. This includes policies and procedures on disclosure of trans (binary and non-binary) identities in making any referrals (i.e. when disclosure is necessary and when it is not), and confirmation with the victim-survivor before doing so.
Ensure staffing, management, governance and advisory structures and composition reflect the diversity of the broader community.	Access regular training on affirming and inclusive service provision from specialist organisations.
Collect data on the diversity of victim-survivors to inform, evaluate and tailor good practice responses and service design.	Have guidelines about the use of professional accredited interpreters, including avoiding using children and other relatives for translation, and promoting the use of interpreters with the same gender as the victim-survivor wherever possible.
Adopt inclusive policies that encourage victim-survivors from a diverse range of backgrounds, cultures and experiences to seek support, for example Disability Action Plans, participation in Pride in Health and Wellbeing and/or the Australian Workplace Equality Index and Reconciliation Action Plans.	Actively engage in cultural and religious learnings of victim-survivors and identify with victim-survivors when and how to incorporate these into service delivery.
Have policies and procedures for intake and assessment conducive to the needs of women and children with disabilities.	
Maintain effective relationships with local DCJ offices to support adult and child safety and wellbeing.	

Guideline 2.1:

Services are culturally safe, responsive and appropriate to the diverse needs and experiences of victim-survivors, including children.

To align with this practice guideline, the practitioner should:
Be non-prejudicial and consistent when assessing a person's eligibility to access a service.
Offer ineligible people a referral to appropriate supports and services.
Explain and contextualise written information in a clear and concise manner to ensure it is understood and provide the opportunity for the victim-survivor and their child to ask questions.
Engage in reflective practice regarding intersectionality and the practitioner's role in maintaining or eliminating barriers to access and cultural safety.
When identifying and responding to forced marriage, refer to the My Blue Sky frontline worker guide which is also found on our Online Resource Toolkit.
Understand the barriers for migrant and refugee people with migration histories especially those with no income due to visa restrictions.

Guideline 2.2:

Practitioners have a thorough understanding of the diversity and intersectionality's of victim-survivor experiences and are culturally safe and responsive.

To align with this practice guideline, the service should:
Offer all staff ongoing training in cultural safety and practice specifically in relation to working with adults and children from migrant and refugee backgrounds and faith-based communities, Aboriginal and/or Torres Strait Islanders, LGBTIQA+ communities and victim-survivors living with disability (including working with AUSLAN interpreters).
Services should implement attitudes and practices that support practitioners and supervisors to fulfil their role effectively. Ongoing training and professional development needs to be supported throughout the various levels of services and organisations to ensure the translation of knowledge into practice.
Adopt inclusive policies and hold regular audits such as accessibility audits: built environment, informational, staff attitudinal, policy and procedures.

To align with this practice guideline, the practitioner should:
Develop and maintain links, points of access and clear referral pathways with other specialist services so that victim-survivors can choose to access a service or services to suit their needs and to be able to change if needed without retribution.
Give the victim-survivor choice of a caseworker or a service that meets their needs, wherever possible.
Demonstrate that they value victim-survivor's, including their children, knowledge and life experiences.
Engage victim-survivors in paid consultation on policies, procedures and service design and delivery.
Engage in reflective practice to understand how their beliefs and values inform their work and the quality of service they offer victim-survivors.
Understand child development and engage age-appropriate strategies to support children.

Guideline 2.3:
Services are accessible and prominent in the community.

To align with this practice guideline, the service should:
Provide disability access and be wheelchair accessible as well as accessibility for people with intellectual disabilities, people with cognitive disabilities, people who are sight impaired and people who are deaf.
Undertake an annual review of accessibility barriers, reflecting and improving from data collected.
Undertake an accessibility audit and create an Inclusion Action Plan and Disability Inclusion Action Plan.
Both the built environment and attitudinal environment (staff knowledge and attitudes) take into account equitable access for people with disabilities.
Where appropriate, have multiple entry points, including soft entry points, and offer child minding arrangements onsite in child-friendly environments or through partner organisations.
Have partnerships with specialist organisations to improve accessibility of the service to key community groups.
Specify a response time to requests for services that is appropriate to level of need and risk.
Promote the service and offer information and resources through a variety of channels, in key community languages and in accessible and inclusive formats e.g. welcome posters in community languages and a rainbow flag or poster, and information in easy read format.
Connect and collaborate with local agencies, community groups and relevant organisations.
Regularly send representatives to attend and contribute to inter-agency forums.
Promote the service and program through a variety of channels, in key community languages and in accessible formats, including at community events.

Guideline 2.4:
Services provide culturally safe and appropriate practice for Aboriginal and/or Torres Strait Islander victim-survivors to be supported and assisted.

To align with this practice guideline, the service should:
Develop meaningful and culturally safe collaborations with Aboriginal and/or Torres Strait Islander organisations that are underpinned by shared respect, shared meaning, shared knowledge, and the experience, of learning, living and working together with dignity and truly listening.[56]
Foster positive relationships and consultation with Aboriginal and/or Torres Strait Islander specific services so that families impacted by DFV feel safe in accessing the service and know that confidentiality will be respected.
Ensure staff have access to ongoing training delivered by Aboriginal and/or Torres Strait Islander people.
Ensure staff are trained in culturally safe practice and working with victim-survivors impacted by intergenerational trauma, dispossession of land and traditional culture, racism and vilification, substance use, the effects of institutionalisation and child removal policies, economic exclusion and entrenched poverty.
Give victim-survivors a choice of Aboriginal and/or Torres Strait Islander or non-Aboriginal and Torres Strait Islander practitioners.

To align with this practice guideline, the practitioner should:
Proactively build trust in Aboriginal and/or Torres Strait Islander communities and with Elders and community members.
Access training and other educational opportunities to develop a thorough understanding of the inherited grief, trauma and loss Aboriginal and/or Torres Strait Islander people continue to experience.
Access training and other educational opportunities to develop a thorough understanding of the complex family and kinship networks in Aboriginal and/or Torres Strait Islander communities.
Work alongside Aboriginal colleagues, clients and services in an open minded, respectful and flexible manner.
Engage in reflective practice regarding supports provided to Aboriginal and/or Torres Strait Islander clients.

Online Resource Toolkit: Principle 2

[56] Department of Health VIC 2021

Principle Three

Principle 3: Domestic and family violence-informed and trauma-informed specialist practice

- **Services are committed to working in a DFV-informed and trauma-informed way that aligns with a strengths-based framework**
- **Services address the impacts of vicarious trauma on staff**

An understanding of the effects of gendered violence and trauma, trauma reactions and trauma-informed practice is essential for all people working with victim-survivors and is considered best and standard practice for the DFV sector.[56] This expertise is critical to avoid re-traumatising victim-survivors and providing an accessible service.

Trauma-informed policies and training are two key strategies in understanding DFV and it's impacts on victim-survivors.

Trauma-informed policies formally acknowledge that victim-survivors, including children, have experienced trauma, commit to understanding experiences of trauma and its impacts, and detail trauma-informed care practices.

Trauma-informed practice, supplemented by DFV-informed assessment and practice that considers the intersections and intersectionality's relevant to children and their families is important to ensure full understanding of the context of risk and protective factors in children's lives.

Ongoing trauma-related workforce training and support helps operationalise these policies. Practitioners need training in the impacts of trauma and the effect that trauma has on a victim-survivor's decision-making ability and how they respond in certain circumstances, including the impact on their parenting role. Ongoing staff support should include regular supervision (individual and group), team meetings and self-care opportunities.

Practitioners also need training on the impacts of trauma and DFV on children's social and emotional wellbeing and the parent-child relationship.

Ensuring Cultural Safety

People from migrant and refugee backgrounds and faith-based communities and Aboriginal and/or Torres Strait Islanders experience racism and discrimination from government agencies, institutions and the public.

LGBTIQA+ people also experience cisgenderism and heteronormativity at individual, organisational and systemic levels, leading to minority stress.

Trauma-informed practice should address the trauma of discrimination, oppression and systems abuse that victim-survivors have experienced and understand how this experience can lead to a fear of engaging with services. Trauma-informed practice needs to recognise these fears as valid and ensure these clients are safe, and feel safe, from prejudice when interacting with DFV services and practitioners.

People with disability are exposed to a range of trauma and retraumatising events throughout their lifetime. Experiences of trauma may result from; institutional 'care', circumstances regarding how disability was acquired (ie: DFV, road accidents), being the target of random abuse in social situations, being put under the 'microscope' much more than that which

[56] Fisher et al. 2020

non-disabled people experience (ie: NDIS). Hence, adults with disability are 4 times (32%) more likely than those without disability (8%) to experience psychological distress, with this often leading to a secondary disability – mental health/psychosocial disability. 'Disability' is a unique sub-culture, and it is on this basis that it is vital that a culturally safe environment aware of, and catering to, the unique trauma experiences and resultant needs of people with disability be provided.[57]

Culture plays an important role in the management and expression of traumatic experiences and identification of the most effective supports and interventions. Culturally safe services respect and respond to the cultural background of victim-survivors, including offering integrated service provision that brings together formal support and informal support that are customary or religious and community-based.[58]

To offer trauma-informed and culturally safe care, practitioners must reflect on their own cultural attitudes and beliefs and understand how this impacts on the services they provide victim-survivors.

Integrated care

Integrated care involves bringing together all the services and support needed to assist individuals, families, and communities to enhance their physical, emotional, social, spiritual, and cultural wellbeing. DFV services need strong relationships and referral pathways with other organisations and networks to facilitate this. This includes children's educational environments.

Women with disabilities can experience DFV from carers, services and in institutional settings, it is important to maintain strong relationships with disability support services that are trusted by the victim-survivor.

Establishing information sharing practices is part of this model and helps reduce the likelihood of retraumatising victim-survivors by making them re-tell their story. This must be done with full knowledge and consent from the victim-survivor.

Integrated care models also offer victim-survivors holistic wraparound support and can enhance the delivery of culturally safe care. Additionally, integrated care can support an early intervention approach for infants and children.

Support client control

Trauma-informed services empower individuals, families, and communities to take control of their own healing and recovery by taking a collaborative, side by side approach. They adopt a strengths-based approach, which focuses on the capabilities that individuals bring to a problem or issue.[59]

Trauma-informed practice enables victim-survivors of trauma, including children, to be supported to regain a sense of control over their daily lives and build competencies that will strengthen their sense of autonomy.[60] Service systems should be designed to keep individuals well informed about all aspects of their support, with the individual, inclusive of children, having opportunities to make daily decisions and actively participate in a healing process appropriate to their needs.

Specialisation

To offer good practice therapeutic and trauma-informed services, DFV practitioners need specialised training and qualifications. Courses are available for DFV practitioners on trauma, attachment and resilience and trauma-informed support. As a minimum requirement, all staff must have ongoing training in working in a trauma informed way.

[57] Australian Institute of Health and Welfare, 2020
[58] InTouch Multicultural Centre Against Family Violence, 2010
[59] Atkinson, 2013; Guarino et al., 2009
[60] Atkinson, 2013; Hopper, Bassuk and Olivet, 2010

Training courses in counselling and therapy will also be relevant to case workers and managers. A good practice response to ensuring a service is trauma-informed is to train all staff in trauma-informed practice, have regular supervision, and support staff to feel confident working in a trauma-informed manner.

Principle 10 offers additional information on training required for DFV practitioners.

Burnout and vicarious trauma

Vicarious trauma or compassion fatigue refers to the changes in a person that can occur when they have repeated secondary exposure to traumatic material.[61] The impacts can be short or long term, and potentially permanent.[62] Burnout is a related concept linked to cumulative stress, work-related dissatisfaction, a sense of hopelessness and inefficacy. Burnout can lead to vicarious trauma and other serious emotional and health problems.

Due to their exposure to traumatic material and frequent contact with service systems that are insufficient and retraumatising, practitioners in the DFV sector can experience a range of negative outcomes from their work, including vicarious trauma and burnout.[63] This is a workplace health and safety issue for DFV services that should be addressed through a range of preventative and remedial strategies.

DFV services must recognise vicarious trauma as a serious clinical issue requiring a therapeutic intervention. Vicarious trauma is also an occupational health risk which can be minimised. To reduce the risk of burnout or vicarious trauma, services working to best practice will encourage informal supervision and self-care activities (such as providing a space to unwind and debrief, build connection, and opportunities to exercise on lunch breaks) to foster resilience. Support from colleagues is a key element in sustaining and developing resilience in practitioners and services should encourage positive and friendly workplace relationships.[64] Services can implement preventative practices to enhance wellbeing and mitigate burnout, as well as setting up regular feedback loops on staff wellbeing. Working within one's own community can pose physical and emotional risks to staff and this needs to be considered in service policy design and implementation. This may be particularly challenging for staff from small or minority ethnic communities, or rural and remote communities.

Professional external supervision for staff is recommended.[65] Services should organise culturally appropriate professionals to undertake external supervision with staff and ensure that staff can vet or choose their supervisor whenever possible.

Services are encouraged to promote 1800 RESPECT as a service practitioner to use when feeling burnt out.

DVNSW also recognise the importance of vicarious resilience, which is the secondary strength, hope and inspiration practitioners in the DFV sector experience when working with victim-survivors. Connecting with vicarious resilience can be an important way of mitigating vicarious trauma.

See Principle 10 for more guidance on supporting staff.

[61] Morrison, 2007
[62] Morrison, 2007
[63] 1800RESPECT, 2021
[64] McCann et al., 2013
[65] Morrison, 2007

Guideline 3.1:
Services are committed to working in a DFV-informed and trauma-informed way that aligns with a strengths-based framework.

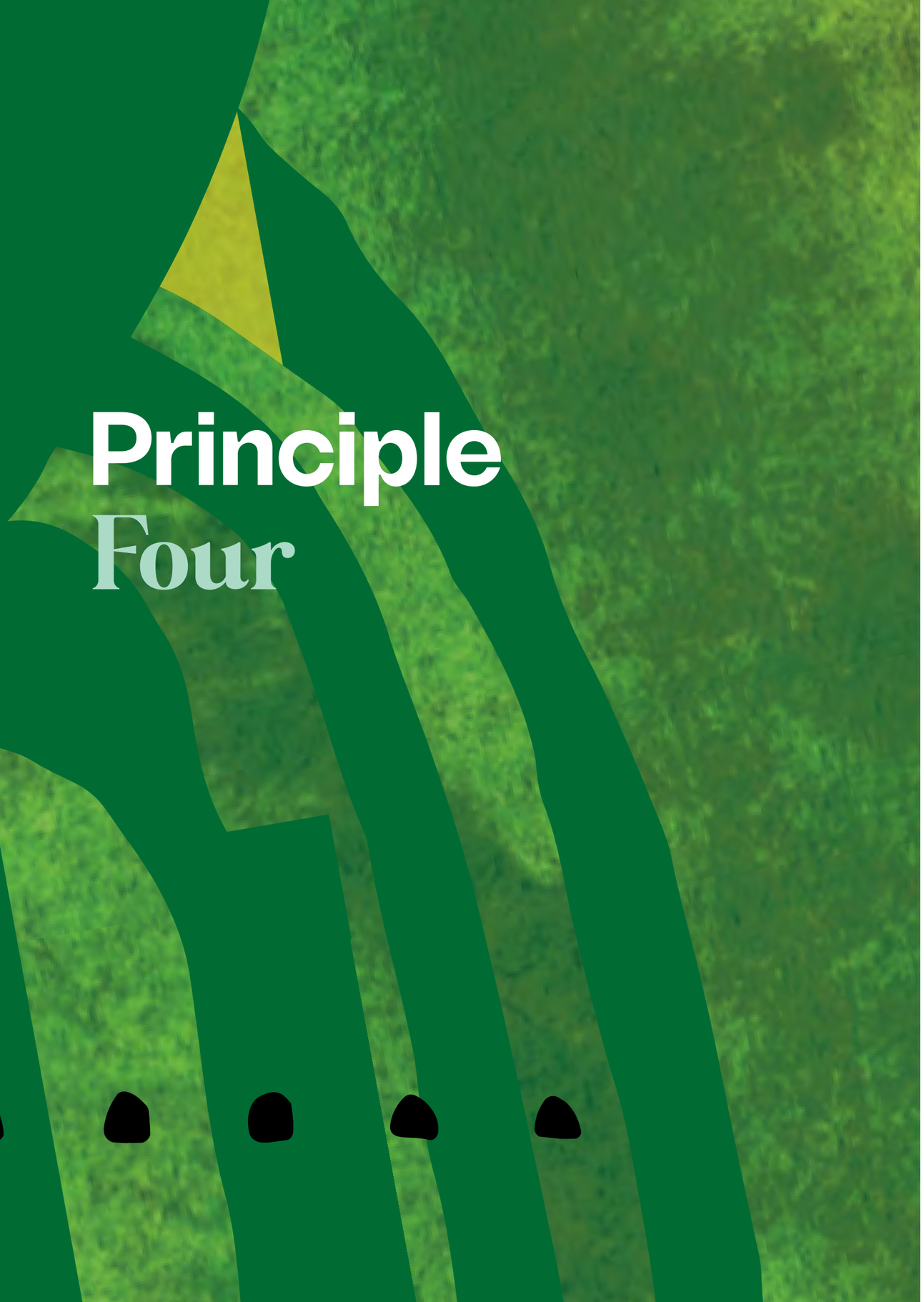
To align with this practice guideline, the service should:
Create and maintain a safe physical space for victim-survivors.
Work collaboratively with other agencies in order to provide continuity of care and best support and assist victim-survivors, including children's physical, emotional, social, spiritual, and cultural wellbeing.
Have trauma-informed policies that formally acknowledge that victim-survivors and their children have experienced trauma, commit to understanding trauma and its impacts for both adults, children and their relationships, and detail trauma-informed care practices.
Have practices and guidelines for supporting the parent-child relationship where adult clients are parents and introduce evidence informed models of practice to strengthen family relationships that help children heal.
Have intake and assessment policies and procedures for asking about an adult's parental status.
Ensure all staff have training on attachment, child development, resilience, and trauma-informed support at a minimum.
Have policies and procedures for supporting infant and children's social, emotional and developmental wellbeing, inclusive of a child-aware, parent-sensitive approach and creating opportunities to work with the parent-client in a way that supports their parenting role and the parent-child relationship.
Provide a safe and well-presented child-friendly area and engaging play materials for a variety of age groups.
Offer all staff ongoing training and professional development in trauma and DFV informed practice; including in how to provide culturally safe responses to LGBTIQA+ people, Aboriginal and/or Torres Strait Islander people, people from migrant and refugee backgrounds and faith-based communities, and people with disability. This is alongside processes to support staff in embedding and enhancing these skills such as supervision.

To align with this practice guideline, the practitioner should:
Be welcoming, friendly, respectful and responsive to the specific needs of the victim-survivor and relate in a way that reflects equality.
Reflect on any biases/beliefs.
Follow the lead of the client as to how past experiences of trauma are managed by themselves and their children.
Be child-aware and parent-sensitive and hold a non-judgemental, curious stance when partnering with parents and children. Make child friendly resources available to help facilitate conversations with children and their family about safety and healing.
Have a nuanced understanding of intergenerational trauma.
Always identify a person with disabilities strengths. See the person, not just the disability.
Be able to explain how trauma impacts a victim-survivor's cognitive, emotional, and behavioural responses and how this may affect a victim-survivor's ability to make decisions or respond appropriately in certain circumstances. Support victim-survivors by normalising their responses.
Be respectful of, and provide responses specific to, a diverse range of cultural backgrounds and beliefs.

Guideline 3.2:
Services address the impacts of vicarious trauma on staff.

To align with this practice guideline, the service should:
Have guidelines to manage the risk of vicarious trauma in WHS policy.
Give staff regular access to trauma support services and professionals.
Provide regular and culturally appropriate external supervision for staff.
Refer to the Australian Association of Social Workers for standards a professional has to meet to be a supervisor.
Promote 1800 RESPECT as a support service available to practitioners.
Offer training on vicarious trauma to management so they can identify burnout and vicarious trauma in staff.
Have a standing agenda item at team meetings to discuss staff emotional wellbeing.
Leadership and/or managers frequently check in with staff about their emotional wellbeing and regularly debrief.
Foster resilience by supporting regular peer debriefing and promote staff wellbeing activities e.g. team lunches, allowing a pet friendly workplace - within allergy range.
Offer staff a variety of work to mitigate vicarious trauma.

Online Resource Toolkit: Principle 3



Principle 4: Victim-survivor centred practice and empowerment

- The service partners with victim-survivors to ensure they are at the centre of all decisions relating to them.
- The service works from an empowering, person-centred and strengths-based framework that is child-aware and parent-sensitive, and practitioners treat all victim-survivors with respect, dignity, sensitivity, and equality.
- The service recognises children and young people as active contributors and clients in their own right.

DFV services need to offer victim-survivors, including children, support that focuses on meeting their needs and is delivered using principles of empowerment. This requires DFV services to work with victim-survivors to build on their strengths and enhance their capacity to make informed decisions and exercise their right to self-determination without coercion and free from judgement.[66] This includes recognising children and young people as clients in their own right, whilst considering the broader context of their relationships and environments.

DFV services must work in a way that supports victim-survivors to experience a sense of control over their lives; as part of this, practitioners must regard victim-survivors as experts in their own lives and safety.[67] Where the victim-survivor would like to work with the whole family, and there is service capacity to do so, this should be enabled.

People in vulnerable and/or in unsafe situations may have reduced capacity for decision making but this does not entitle the practitioner to make decisions for them. Instead, it invites the practice of empowerment and encouragement of agency.

***SHS providers** should note the alignment between this principle and ASES Principle:*

- *Customer and outcome focused*

[66] Sen 2019

[67] Family Safety Victoria 2019; Toivonen and Backhouse 2018

DFV services offering victim-survivor centred practice and empowerment should:[68]

- Believe disclosures of violence and abuse.
- Recognise and enhance the personal resources of victim-survivors.
- Give adequate and transparent information so victim-survivors can make informed choices, provide input into the service, and support they are offered.
- Have processes in place to prevent victim-survivors from having to re-tell their story multiple times to different practitioners or services. This requires providers to have strong working relationships with local partners, facilitating lawful and efficient information sharing.
- Acknowledge the experiences of victim-survivors in a non-patronising way.
- Build on client strengths and increase their capacity to make informed decisions.
- Name and support acknowledgement of acts of resistance and autonomy.
- Assist in identifying the risks faced in the victim-survivor's individual situation.
- Identify practical support for the development of strategies that maximise the safety and wellbeing of victim-survivors
- Recognise children and young people as clients in their own right.
- Engage in practices that promote safety, trust, and respect by providing opportunities for children and parents to share their strengths, hopes, worries, and concerns.
- Adopt child-aware and parent-sensitive practices that aim to enhance the social and emotional wellbeing of children and young people.

Intersectionality in victim-centred practice and empowerment

Victim-survivors are vulnerable because of how systems and structures target and discriminate against them, not because of their identity or community. Services need to acknowledge the strength and resilience of victim-survivors that experience multiple forms of discrimination and facilitate the victim-survivor's agency in making choices for themselves.

Services and practitioners must not impose goals or outcomes on victim-survivors that come from a mainstream Western cisgender or heteronormative perspective. This includes recognising faith as a source of empowerment for some victim-survivors.[69]

Children and young people are clients in their own right

The UN Convention on the Rights of the Child informs an understanding of children's right to survival, safety, development and participation. Understanding and advocating for children and young people as victim-survivors in their own right enables purposefully created safety plans and case management using a child-centred, culturally responsive approach.

All practitioners have a role to play in supporting the social and emotional wellbeing of children and should have a foundational understanding of the impact of DFV on infants and children, as workers in services will encounter women and their children affected by the impact of family violence. Additionally, practitioners will encounter victim-survivors who may be pregnant, a parent or caregiver to a child that is in or out of their care or who may become a parent or caregiver in the future. By adopting a child-aware approach (see Foundational Concepts page 21) practitioners create an opportunity to work with the parent-client in a way that supports both their parenting role, and also the child's social and emotional wellbeing. This supports parents to create a solid foundation for their children's mental health outcomes later in life.

Victim-survivor centred practice and empowerment principles apply to children and young people impacted by DFV. Services and practitioners must recognise children and young people as clients in their own right and actively promote opportunities to engage with children that are appropriate to their developmental stage. Children and young people's experiences of violence can be different to the parents and risk assessment should be done separately, for example a child may have been sexually abused but the parent was not, or the protective parent may also have caused harm to the child.

Direct engagement can be limited due to factors such as the child's age and stage of development and the parent or carer's engagement with the service.[70] When direct engagement is limited, children's rights and safety need to be prioritised in service delivery through child-centred practices that consider the broader context of the child's relationships and environments.

To enable child-centred practice, practitioners and services need to understand the impacts of DFV on children and young people and develop organisational cultures and coordinated service responses promote the safety and wellbeing of children.

Age, and developmentally appropriate support to help children of all ages (and their protective parent) understand and identify potential risks and ways that the perpetrator may use the child to continue to perpetrate violence or control following separation (e.g. contact / handover times, interrogating the child re: victim-survivor's actions (59% children and young people said they had feelings of guilt for disclosing information to the offending parent)[71] surveillance, using tracking 'devices') and when there is no separation (e.g. undermining / impacting their relationship with their other parent, impacting on the family functioning and child's wellbeing, being co-opted into coercive control actions against the victim-survivor).

Prompting questions can help when talking to children and young people to understand their situation, trauma and impact of DFV:

"You appear to be really tired today. Is there a reason you're maybe not getting enough sleep?"

"Have things changed at home recently?"

"Tell me about the good things at home"

"Is there someone at home that makes you feel safe?"

"Can you talk to them if you had a problem or were worried about something?"

"Are there other adults who make you feel safe that you might be able to talk to?"

"Are there things at home you wish you could change?"

"Does anyone living in your home do things that make you feel unsafe or scared?"

"Tell me about the ways mum/dad/family member or carer look after you?"

"Do you worry about your mum/dad/brothers/sisters for any reason?"

[68] Toivonen and Backhouse, 2018; Family Violence Victoria, 2019; Sen, 2019

[69] Muslim Women Australia, 2020

[70] Domestic Violence Victoria, 2020

[71] Esafety commission – impacts of TFA on children webinar, Sept 2022

Case study
DV West

DV West offers supported crisis accommodation, transitional housing, outreach support, a counselling service, a legal clinic and an after-hours service to support victim-survivors in the Nepean Blue Mountains, Hawkesbury and the Blacktown Hills districts. DV West provides an Aboriginal specific service through Wirrawee Gunya that is managed and run by Aboriginal staff. It includes a refuge, Transitional Housing, groups and outreach services.

DV West has used the Good Practice Guidelines as a baseline to implement the Safe and Together Model. The Model aims to keep children together with the non-offending parent and partners with the mother/carer to document the perpetrator's parenting choices, pattern of behaviour and impacts. The Model uses a comprehensive strength lens to identify and document the actions and strategies the non-offending parent has used to protect and nurture the children's safety and wellbeing. It goes beyond the systems measures of child protection like calling the police, taking out an AVO or leaving and recognises that these actions are not suitable and safe for all victim-survivors and their children. Our organisation has trained all staff in the Safe and Together Model. We have found that the training followed by the practice has noticeably unified the skills and knowledge of all our staff (30), regardless of whether they have worked in the sector for 1 year or 20 years. Catherine Gander, CEO of DV West, sees the effectiveness of the model daily: "The model gives workers an increased ability and confidence to partner with victim-survivor and gather information to advocate across systems effectively. It focusses its' documentation and approach towards holding the perpetrator to account and shifting the responsibility for the violence and its impacts away from the victim-survivor. For example, we support many victim-survivors who have had their children removed or their children are at-risk of removal. Through using the Safe and Together Model we have seen most children returned to their mothers, or not removed at all. The Model has excellent tools to focus our documentation and support to victim-survivors in an efficient and effective way. The Good Practice Guidelines overlayed with the Safe and Together Model is a mutually beneficial combination that has elevated our practice and outcomes to another level."

Using the Good Practice Guidelines, overlayed with the Safe and Together model, DV West partner with victim-survivors to understand the strategies they have used to protect themselves and their children, taking a trauma-informed and domestic violence-informed approach.

To monitor and continuously improve their work, DV West regularly review client outcomes and compares case studies to identify what is working and what is not. To formalise this approach, DV West has completed an outcomes evaluation and will use the results and learnings to inform future methods of evaluation and practice. DV West is of the view, that data entry, influences practice. The organisation is currently advocating to have a perpetrators tab included in the SHS data collection system. Having the capacity to document and easily access information on the perpetrators patterns of behaviour and their impacts on the family's safety and wellbeing, increases our capacity to support and advocate for safe arrangements, not only in our own service but across systems.

Children who witness violence can go on to perpetrate violence, however this is often a response to their experiences of trauma. Services should support children and young people who use violence through partnerships and referral pathways with appropriate services that aim to view the child within the context of their experiences of DFV and the subsequent impacts on the parent-child relationship and sibling relationships.

Practitioners working with children and young people who have experienced DFV need specialised knowledge and skills. Providers running short courses on working with children and young people who have experienced DFV include:

- Australian Childhood Foundation
- Association of Children's Welfare Agencies: Centre for Community Welfare Training
- Domestic Violence Resource Centre Victoria
- Education Centre Against Violence (ECAV)
- 54 Reasons
- Emerging Minds
- Safe and Together

Practitioners who specialise in working with children and young people should consider undertaking an accredited qualification in this area. For example, the 10800NAT Graduate Certificate in Developmental Trauma offered by the Australian Childhood Foundation examines how to apply the knowledge base about the neurobiology of trauma to support children and young people.

DFV services must meet the Child Safe Standards and the National Principles for Child Safe Organsations; these frameworks help services create child safe organisational cultures that keep children from harm and ensure their wellbeing. Out of Home Care and Voluntary Out of Home Care providers are legislatively required to implement additional safeguards.[72]

The Online Resource Toolkit offers additional resources that may be helpful in implementing this principle for children and young people impacted by DFV.

[72] Policies and legislation for out of home care providers can be found here: https://www.facs.nsw.gov.au/families/children-and-families-policies-and-legislation/policies-and-law/out-of-home-care

Registration and monitoring requirements for VOOC providers can be found here: https://www.ocg.nsw.gov.au/voluntary-out-of-home-care/registration.

Guideline 4.1:

The service partners with victim-survivors to ensure they are at the centre of all decisions relating to them.

To align with this practice guideline, the service should:
Have policies that clearly promote the rights of the victim-survivor, such as a charter of client rights.
Develop and implement child and family partnership strategies across all areas of their service to ensure the lived experience voices of families is reflected in service delivery.
Have accessible complaint mechanisms in place.
Ensure that intake and assessment processes include identification of clients as parents and take into account experiences of trauma and safety, needs and goals, risk and information sharing processes.
Use intersectionality as a framework for reflection, supporting practitioners to identify and address unconscious biases that may cause them to be judgemental towards a victim-survivor or their choices or priorities.

To align with this practice guideline, the practitioner should:
Breakdown decisions into manageable options.
Ensure victim-survivors and their children are aware of their rights and the available complaints and feedback mechanisms through the service and other services they are accessing where available.
Provide victim-survivors with information about available options for meeting their needs and assist them to identify options to meet those needs without overwhelming them (further information on this can be found in Principle 8).
Create separate case plans for each child and ensure parent/guardians are offered opportunities to explore the impacts of DFV on the social and emotional wellbeing of their child/ren.
Ensure victim-survivors, including children, have autonomy over decisions that impact their lives.
Actively promote the principle that the victim-survivor and their child/ren is the expert in their own life, respect this expertise and acknowledge that this is fundamental to the safety of the victim-survivor.
Review case plans regularly and ensure the victim-survivor's decisions and ideas, including those in relation to their parenting, are thoroughly integrated into their case planning and review.

Guideline 4.2:

The service works from an empowering, person-centred and strengths-based framework that is child-aware and parent-sensitive, and practitioners treat all victim-survivors with respect, dignity, sensitivity and equality.

To align with this practice guideline, the service should:
Have systems, processes, and partnerships to minimise the need for the victim-survivor to re-tell their story.
Ensure a victim-survivor is not at any disadvantage if they choose not to engage with the service or receive support from another service.
Ensure organisation policy and practice supports a person-centred and strengths-based approach.

To align with this practice guideline, the practitioner should:
Listen and follow the lead of victim-survivors, including children and young people.
Use holistic, strengths-based and empowering approaches in providing support.
Promote respectful relationships with victim-survivors where the safety of children and families is discussed openly, safely and sensitively.
Understand the complexity of DFV, the impacts of trauma on the parent-child relationship and the opportunities to support positive wellbeing and safety within the family.
Validate the experience of the victim-survivor and never put pressure or blame on them, even if they take action the practitioner does not think is in the best interests of the victim-survivor.
Be transparent about their role and the capacity in which they can assist the victim-survivor, including limitations of the work and the practitioner/victim-survivor relationship.
Recognise and name acts of resistance, strength and resilience.

Guideline 4.3:

The service recognises children and young people as active contributors and clients in their own right.

To align with this practice guideline, the service should:
Ensure organisational policies, procedures and practice adopt Child Safe Standards and a Child Safe Policy.[73]
Ensure policies, procedures and practices support the physical, social and emotional wellbeing of infants and children.
Work with children and young people as victim-survivors in their own right wherever possible including individual case, risk and safety planning, offering support for children and young people around the impacts of trauma and DFV.
Have established links and referral pathways with other agencies that provide continuity of care and can support the wellbeing of the children and young people where they require specialised support.
Have appropriate trauma-informed procedures in place for children and young people who use violence within the service, alongside referral pathways that support these children and young people to receive appropriate support.

To align with this practice guideline, the practitioner should:
Have a comprehensive understanding of the way DFV affects and impacts children and young people, including the stress on the parent and therefore the parent-child relationship, and can share this information respectfully with the parent, and young person if appropriate.
Support children and young people in ways that are sensitive to their experiences and view them as active, knowledgeable contributors.
Inform children and young people in age-appropriate ways of their options and choices.
Ensure case plans for children and young people include their personal aims, goals and voice in an age-appropriate manner.

Online Resource Toolkit: Principle 4

[73] See Office of the Children's Guardian for advice and resources on meeting the Child Safe Standards and developing a Child Safe Policy.

Case study
Wirringa Baiya

Wirringa Baiya provide legal and non-legal support to Aboriginal and Torres Strait Islander women and children across NSW. Wirringa Baiya was established as a legal centre in 1997 in response to unmet need for legal support for Aboriginal and Torres Strait Islander women and children experiencing domestic and family violence. Most Wirringa Baiya clients need support with domestic and family violence, sexual assault and family law matters.

Wirringa Baiya is a trauma-informed and culturally safe practice. Christine Robinson, CEO of Wirringa Baiya explains: 'We are client centric and work with our clients long-term and at their pace, understanding the impact of trauma, colonisation and the barriers which present for Aboriginal women.'

To achieve sustainable outcomes for clients, Wirringa Baiya offer victim-survivors a holistic service that includes non-legal supports. Non-legal support is delivered by an Aboriginal case worker and can include: preparing/assisting with cultural plans; referrals; parenting; housing and accommodation assistance; financial support and advocacy and cultural and emotional support for clients in court and in meetings with the Police and government agencies.

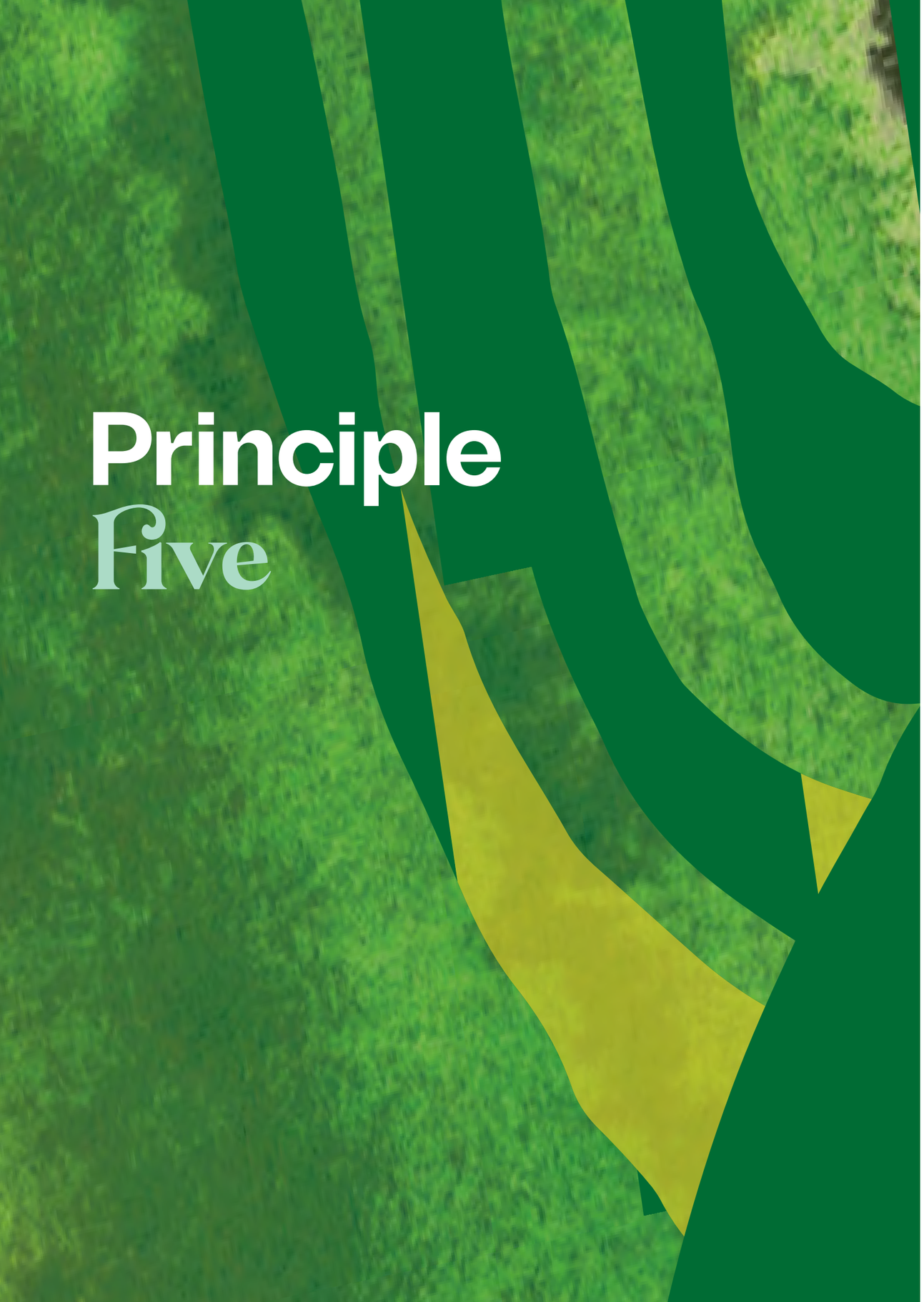
The Wirringa Baiya Governing Committee is composed entirely of Aboriginal women from diverse communities with comprehensive understandings of domestic and family violence. All non-legal positions are Aboriginal identified and the Centre is Aboriginal community controlled, promoting self-determination and building community trust.

Christine emphasises the role that community partnerships play in helping Wirringa Baiya reach victim-survivors in regional and remote communities: 'we have strong networks and Aboriginal community and cultural connections across NSW. Many Aboriginal communities have trust and confidence in us, giving us unique access to high-risk communities.'

Wirringa Baiya also support Aboriginal and Torres Strait Islander women in NSW prisons and offer free community legal education across NSW.

Wirringa Baiya clients often have a high level of legal need and may require multiple services connected to or caused by their experience of domestic and family violence such as adult sexual assault, child sexual abuse and child protection matters.

Building trust with clients and communities is key to uncovering legal and non-legal issues victim-survivors are facing. Christine explains: 'this can be time and resource intensive, but it is critical to ensuring the client's needs are being met in a trauma-informed and culturally safe manner'. We know that every client, every family and every community is different and work in ways that support their unique needs.



Principle Five

Principle 5: Confidentiality and informed consent

- **Victim-survivors have their right to confidentiality and privacy respected and are informed of situations where their right to confidentiality may be limited.**
- **Victim-survivors have a right to access their data.**
- **The service meets ethical and legal obligations in relation to confidentiality and privacy. The service also has secure record-keeping procedures and informs victim-survivors of these procedures.**

Confidentiality and privacy are key when working with victim-survivors of DFV. A breach of confidentiality can be dangerous and detrimental to a victim-survivor's safety, as well as having potential implications for the service, practitioner or other clients. Victim-survivors trust practitioners with highly personal information and have a right to expect that this will be kept in confidence and used appropriately.

Practitioners and services must comply with legislative and regulatory obligations regarding privacy and confidentiality of victim-survivors.[74] Privacy laws control the ways in which personal information, including sensitive information and health information, is collected, used, stored, shared and disposed of.

Victim-survivors must be fully informed about:

- What information is collected and recorded by the service and how this information is stored.
- The limits to privacy and confidentiality.
- How they can access their information.
- How the information is used by the service.
- How the service obtains ongoing and informed client consent.

Where these conversations involve children, this information needs to be presented in child-friendly, developmentally appropriate ways.

For people living in rural and remote areas, concerns about privacy and confidentiality present an additional barrier to seeking assistance as residents are often well known to each other and a person's physical movements may be more easily observed than in metropolitan environments.

Where a population is relatively small and connected, including in urban areas, services should consider how community links can impact on the confidentiality and privacy of victim-survivors, for example the local police officer may know a victim-survivor and/or the perpetrator.

People from migrant and refugee backgrounds and faith-based communities, Aboriginal and/or Torres Strait Islanders, LGBTIQA+ people and other community members can fear that confidentiality will be breached by service providers or authorities. Services have an obligation to address these issues with victim-survivors in the initial stages of intake, to be honest about any limits to confidentiality, and have strategies in place to reduce any conflict of interest or breach of confidentiality.

[74] For example Privacy and Personal Information Protection Act 1998 (NSW), Health Records and Information Privacy Act 2002 (NSW), Privacy Act 1998 (Commonwealth), NSW Crimes (Domestic and Personal Violence) Act Part 13A and the related Domestic Violence Information Sharing Protocol, Children and Young Persons (Care and Protection) Act Chapter 16A

When sharing information, service providers are to be guided by the principles of the NSW Department of Justice Domestic Violence Information Sharing Protocol:[75]

- The safety of victim-survivors and their children is paramount.
- Individuals have rights to both safety and privacy, but where these rights are in tension, victim-survivors' safety comes first.
- There is a presumption that informed consent to share information must be sought and obtained from victim-survivors. However, there are some limited exceptions to the requirement for consent.
- Victim-survivors can choose the service providers with which they engage.
- Victim-survivors have the right to receive domestic violence support services without consenting to information sharing.
- Victim-survivors have the right to access information held about them by service providers, and are able to correct that information.
- Information shared must be secure, timely, accurate and relevant.

Responsible use of data

As a result of collecting personal information from victim-survivors, DFV services can develop data sets on specific populations. Services have a responsibility to be proactive about the responsible collection and use of this data.

Services should develop robust data collection methods and tools that adequately capture the diversity of victim-survivors and offer quality services. For example, a DFV service needs to record more than a country of birth to understand the cultural diversity of its clients. First and second-generation Australians still experience barriers to access that relate to their multiple identities, and require culturally, linguistically and religiously appropriate support.[76] Another example is a hidden disability which may impact how a victim-survivor engages with a service.

If a service is using and/or sharing aggregate and de-identified data (e.g. in submissions, funding applications or advocacy), services need to ensure it is not used against the interests of the communities it relates to. If the data a service is collecting identifies issues affecting a specific community, the service should find safe ways to share this data with the community.

[75] Department of Justice, 2017

[76] Muslim Women Australia 2020

Guideline 5.1:

Victim-survivors have their right to confidentiality and privacy respected and observed and are informed of situations where their right to confidentiality may be limited.

To align with this practice guideline, the service should:	To align with this practice guideline, the practitioner should:
Have confidentiality policies that outline the service's approach to confidentiality and the limits of confidentiality, and support practitioner adherence to legislative, regulatory and funding obligations.	Explain the confidentiality policy to the victim-survivor utilising communication method/s which they can understand, for example sign language, communication device, pictures, easy read format, languages other than English.
Have a policy on not 'outing' victim-survivors who disclose information relating to their gender, sexuality or health as part of their confidentiality policy.	Inform the client and seek their involvement, when safe to do so, when the practitioner has shared or disclosed, or is intending to share or disclose, personal information without consent because of duty of care or other legal obligations.
Have a mechanism for victim-survivors to offer feedback on their understanding of the confidentiality policies, including limitations of confidentiality.	Obtain fully informed written and verbal, or in a format suitable for a person with disability, consent for each victim-survivor. Where it is possible to gain only verbal consent, practitioners clearly document in case notes the circumstances in which consent was obtained.
Have information management and sharing processes that respect client autonomy and promote their involvement in decision making processes. This includes seeking client consent and involvement in the collection, use and sharing of their personal information wherever it is safe, lawful and possible to do so and not just as required by law. Consent must be voluntary, informed, specific, current and provided by someone with the capacity to do so.[77]	Wherever possible, ensure exchanges with victim-survivors occur in a private space.
Inform the client and seek their involvement, when safe to do so, when the service has shared or disclosed, or is intending to share or disclose, personal information without consent because of duty of care or other legal obligations.	To ensure victim safety and confidentiality, the practitioner should discuss with the victim-survivor their preferred explanation and/or process for being together if an exchange were to occur in a public space (whether planned or unintentionally).
Access the Sexual Assault Communications Privilege Service education and support services to help protect the privacy of counselling notes and other confidential therapeutic records in criminal proceedings involving sexual offences.	To ensure victim safety and confidentiality, the practitioner should discuss with the victim-survivor their preferred explanation and/or process for being together if an exchange were to occur in a public space (whether planned or unintentionally).

[77] Information and Privacy Commission NSW 2019

Guideline 5.2:
Victim-survivors have a right to access their data.

To align with this practice guideline, the service should:
Have policies on confidentiality that consider issues relating to limitations, including mandatory reporting of suspected child abuse or neglect, the share and exchange of information with other services/agencies, protocols pertaining to a breach in confidentiality, discussion of the case in supervision or team meetings, subpoena of information by courts etc.

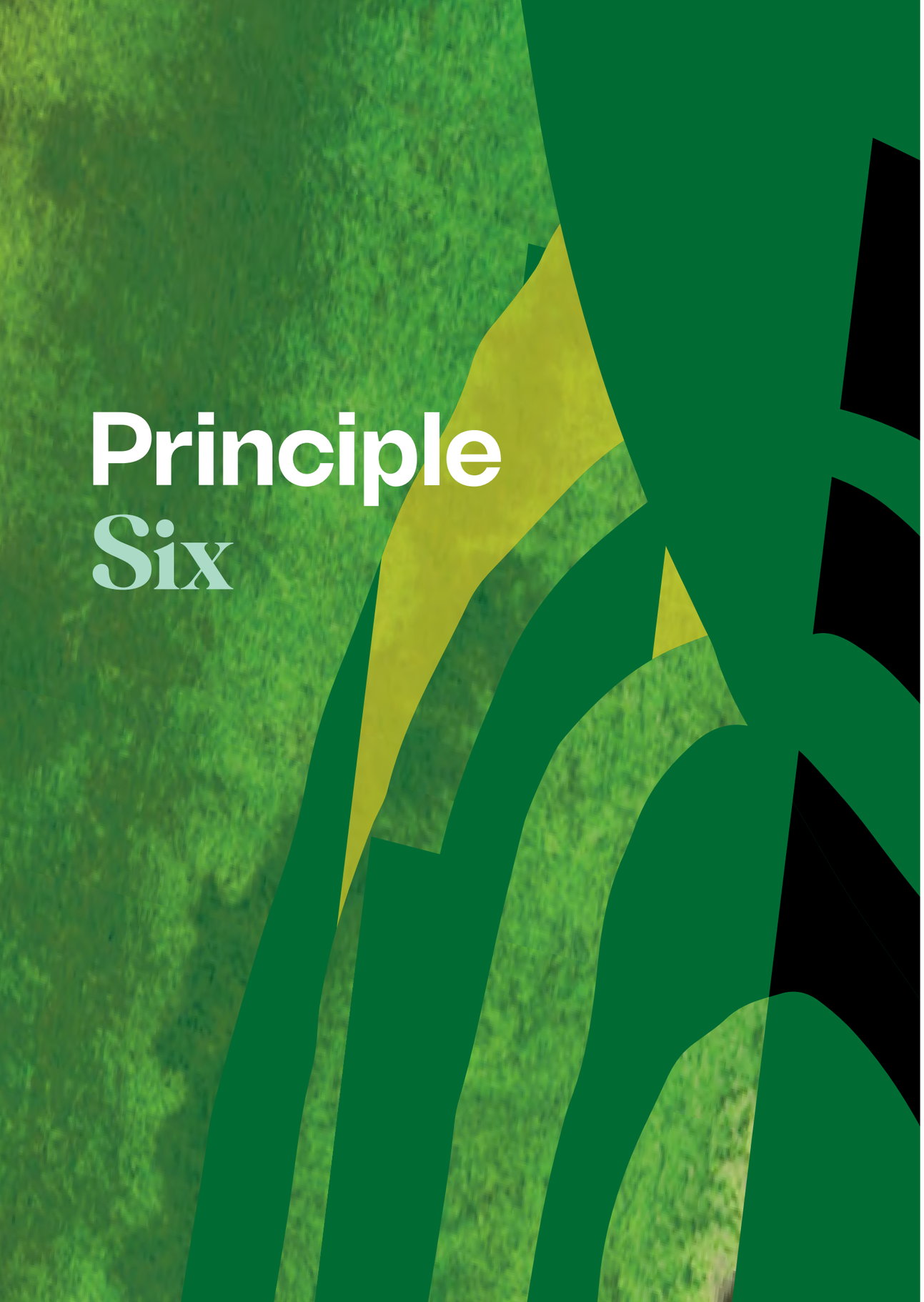
To align with this practice guideline, the practitioner should:
Provide clear guidance to the victim-survivor on the importance of privacy and confidentiality (such as not disclosing location and identity) to protect their safety and the safety of others.
Understand the limits of confidentiality and be able to discuss this with their client.
Be flexible with meeting times and locations to ensure safety and confidentiality are maintained.

Guideline 5.3:
The service meets ethical and legal obligations in relation to confidentiality and privacy. The service also has secure record-keeping procedures and informs victim-survivors of these procedures.

To align with this practice guideline, the service should:
Have a Code of Ethics or Code of Conduct and give all staff training or information about what this entails.
Have a policy on record-keeping and advise victim-survivors of this policy and their rights to access and request amendment of personal information held by the agency.
Ensure all files, records and case notes are stored securely, including electronic information.
Take security measures to prevent any records from being seen, used, copied or removed by anyone who does not have authority (this includes electronic security measures).
Have clear guidelines on who has the authority to access client information, the process victim-survivors must follow to gain access to these records and details of when and how the records will be destroyed.
Have clear protocols for exchange and disclosure of information relating to children, including requests from parents that are perpetrators. It is recommended that services seek legal advice in the development of these policies and procedures and document all communication clearly.

To align with this practice guideline, the practitioner should:
Accurately record information.
Be capable of preparing legible court reports and providing evidence that focuses on the best interests and safety of victim-survivors.
Consider how the provision of information relating to children may impact the perpetrator's behaviour and the family dynamic.

Online Resource Toolkit: Principle 5



Principle 6:
Non-judgemental support

- **Services support, listen to, and respond to all victim-survivors in a respectful, dignified, sensitive and non-judgemental way.**
- **Practitioners provide safe, non-judgemental and inclusive surroundings.**

DFV services and practitioners must be respectful, welcoming, non-judgemental, safe and inclusive.

Practitioners must establish trusting, empowering and supportive relationships with victim-survivors and ensure all communications and interactions with victim-survivors are undertaken with sensitivity, care and dignity.

Victim-survivors must be treated as individuals and not judged, discriminated against, or stereotyped according to their disability, cultural background, sexuality, religion, profession, age, gender experience or any other affiliation. DFV services work to ensure the safety of victim-survivors, this includes ensuring they are safe from prejudice or discrimination from the service itself, practitioners and other service users. Services and practitioners need to use intersectionality as a framework to acknowledge and examine their own biases and the impact of this on the support they offer victim-survivors.

Victim-survivors return to/do not leave violent relationships for many complex reasons. It is important that practitioners understand this and challenge any judgement they may feel about this. Questioning a victim-survivor's choice to stay or return may result in them disengaging from the service, which presents a further risk to their safety. Instead, the practitioner should provide support for victim-survivors to be safe regardless of their relationship status.

DFV service provision must be committed to the victim-survivor's right to self-determination and empowerment, as described in Principle 4. Services must establish universally designed feedback mechanisms for victim-survivors and make these accessible, as required by the Community Services (Complaints Review and Monitoring) Act 1993. Other opportunities or processes for feedback from victim-survivors may include, but are not limited to, victim-survivor advisory groups, case review process and satisfaction surveys distributed to clients while they are engaged with the service and on exit.

***SHS providers** should note the alignment between this principle and ASES Principle:*

- *Valuing people and diversity*

Guideline 6.1:
Services support, listen to, and respond to victim-survivors in a respectful, dignified, sensitive and non-judgemental way.

To align with this practice guideline, the service should:
Have policies and practices in place that nurture victim-survivor choices.
Have systems, processes and practices to uphold and promote victim-survivor rights and seek to increase victims-survivor awareness of these rights.
Take an intersectional approach to working with victim-survivors who have complex needs and/or experience intersecting forms of discrimination.
Have links and/or collaborations with multicultural services to support the cultural needs of victim-survivors and to ensure practitioners are culturally safe.
Have links and/or collaborations with Disability services to support the needs of victim-survivors living with disability and/or children living with disability.

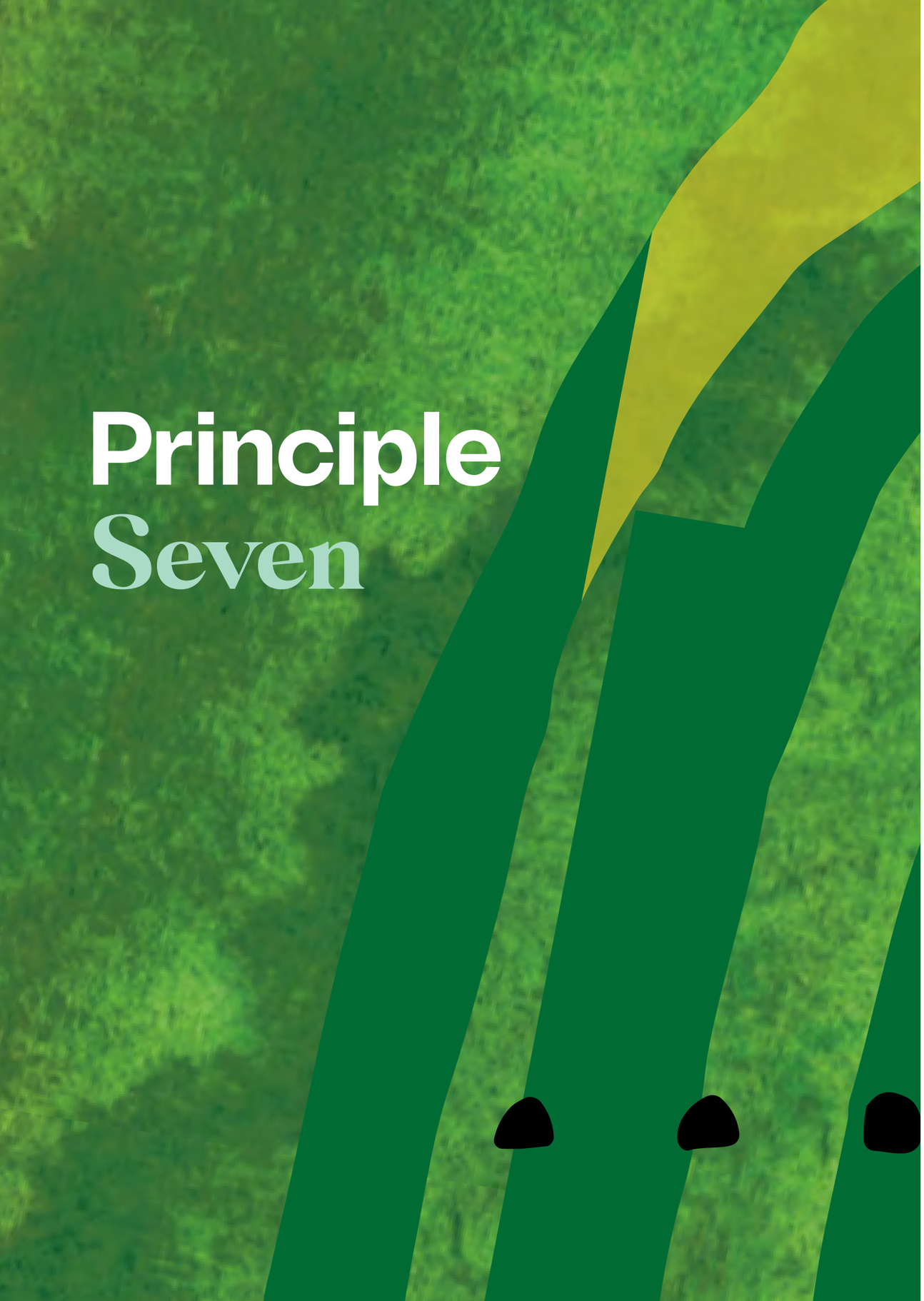
To align with this practice guideline, the practitioner should:
Offer empathetic and affirming support that targets the individual needs of victim-survivors, including children.
Provide victim-survivors with information about their right to be treated with respect and without judgement.
Provide appropriate and effective referral pathways to other services as required.
Accept what the victim-survivor says without being judgemental and never blame the victim-survivor for the violence.
Utilise a strengths-based approach, particularly when working with people with a disability and people who have experienced, or are experiencing, trauma.
Understand the complex and personal reasons victim-survivors return to violent relationships, and not judge a person's reasons for remaining in a violent relationship.
Validate and acknowledge the victim-survivor's experience and support their choices.

Guideline 6.2:
Practitioners provide safe, non-judgemental and inclusive surroundings.

To align with this practice guideline, the service should:
Provide staff with regular peer and external supervision.
Regularly undertake case reviews as a team.
Use intersectionality as a framework for reflective practice at the organisational and practitioner levels.
Provide a variety of programs, strategies, and resources to meet the diverse needs of victim-survivors, including telephone and face to face crisis support, information, and referrals to appropriate services, advocacy, support and counselling, group work, outreach and follow up work.
If affiliated with a religion, a service should highlight that religious beliefs will not be imposed on victim-survivors. The service should be mindful that victim-survivors may fear judgement or pressure to adopt the religious beliefs of the service.
Have accessible mechanisms for feedback and client complaints.

To align with this practice guideline, the practitioner should:
Be aware of their own beliefs, values and parenting style and consider how these may impact their work with victim-survivors, including those with diverse needs.
Work with a sense of curiosity and respect the beliefs and values of victim-survivors.
Attend regular training on working with victim-survivors with diverse needs including cross cultural training, working with interpreters, issues for LGBTIQA+ people impacted by DFV, victim-survivors living with disability, elder abuse, mental health issues, young people and mothers.

Online Resource Toolkit: Principle 6



Principle 7: Collaboration

Services are committed to actively engaging with the local service ecology and improving the outcomes of victim-survivors, including children, through coordination, collaboration and integration that provides continuity of care.

Effective multidisciplinary collaboration helps coordinate supports, improving the quality of services by providing inclusive and integrated responses, reducing the risk of family violence to children[78] and benefitting service providers by improving working relationships and using resources more efficiently.[79] Collaboration also amplifies efforts to bring about systemic change to the prevention and response to DFV through advocacy that can support sustainability.

Collaboration can include:[80]

- Referral processes and pathways
- Co-case management
- Co-location
- Secondary consultations to seek advice from, or give advice to, another service
- Information sharing
- Participation in interagency and network meetings e.g. Safety Action Meetings.
- Participation in community networks and partnerships
- Joint submissions to government enquiries

Collaboration supports intersectional and child-centred approaches to DFV service delivery by linking victim-survivors to organisational support. Services should ensure strong links to services and other key collaborators such as health services, local police, legal services, court support, translation services, youth services, housing providers, domestic and family violence networks, men's family violence services and other interagencies, disability services and other homelessness services.

Collaboration gives DFV services the opportunity to respond not only to violence and trauma but factors that often co-occur in complex cases such as homelessness, substance use and mental health issues. Where appropriate, services should coordinate cases and co-case manage victim-survivors who present with complex issues. For example, victim-survivors living with cognitive or intellectual disability may require a dedicated support practitioner to help them understand and remember key information, access to financial resources to support their independence and housing assistance.[81]

***SHS providers** should note the alignment between this principle and ASES Principle:*

- *Collaborative work practices*

[78] Fitz-Gibbon et al. 2019
[79] Stewart, Lohoar and Higgins 2011
[80] Domestic Violence Victoria 2020; McCulloch et al. 2016
[81] People with Disability Australia and Domestic Violence NSW 2021

Further, as many children exposed to DFV often live with complex issues services should seek multidisciplinary and cross-agency collaboration to support continuity of care for children and their families with multiple and complex issues, and collaboratively support the social and emotional wellbeing of children and their families. When referring children to specialist / mainstream services clearly identify the perpetrator's behaviours as the source of harm to the child and the protective strengths the victim-survivor uses to promote safety, healing, wellbeing and stability.

Facilitating sustainable and accessible networks of support for children and young people who have experienced DFV include formal and informal people and services that children and young people have identified as safe, trusted and accessible to be contacted at the times needed.

Good multidisciplinary collaboration includes information sharing, interpretation and discussion. This enables more informed decisions to be made on risk assessment and management.[82] This can take the form of referrals, formal reporting mechanisms, case conferences, information sharing and joint planning processes. It may involve anything from a simple telephone call to an extensive range of interagency protocols.

DFV services must offer staff opportunities to develop and maintain strong working relationships with other local agencies. Practitioners need a thorough knowledge of, and access to, specialist and mainstream agencies and organisations responding to DFV in their local area. Working in isolation from agencies that are, or need to be, involved in the response can lead to fragmentation, duplication and lack of critical information for establishing the immediate and future risks to those experiencing trauma.

Effective collaboration means building trust, respecting expertise, being open and transparent and respecting each work and practice styles. Collaboration includes taking the lead from organisations with specialist expertise related to certain communities or populations and supporting the work they do. Maintaining a focus on client outcomes throughout the collaboration is critical.

Services must have clear processes for dealing with disputes or grievances that arise between agencies or services and a shared framework of responsibility across services.[83] Good collaboration requires clearly defined shared aims and shared understandings and processes for working productively for the safety and wellbeing of victim-survivors.

[82] Domestic Violence Victoria 2020

[83] Fitz-Gibbon et al. 2019

Guideline 7.1:

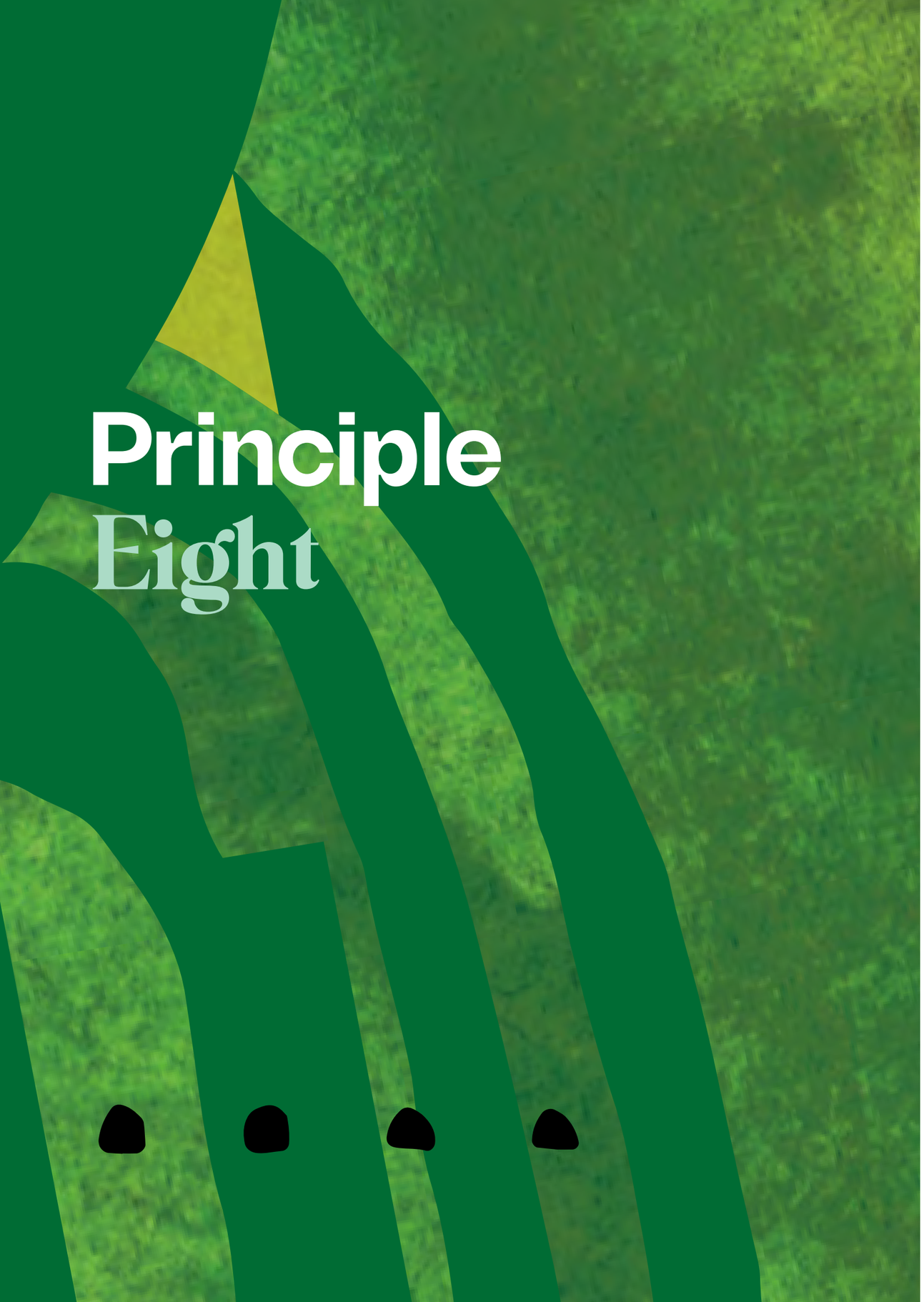
Services responding to DFV are committed to improving their services, and the outcomes of victim-survivors including children, through coordination, collaboration and integration that provides continuity of care.

To align with this practice guideline, the service should:
Commit to working with NSW Police Force, Child Protection, Local Coordination Points and participating in Safety Action Meetings and other case coordination structures.
Regularly participate in interagency and network meetings and be part of community networks.
Have clear referral processes and pathways and information sharing protocols that are child-aware and parent-sensitive.
Have strategies in place for working collaboratively with key partners within their local area to improve outcomes for victim-survivors including children. This may require initiation of routine case discussions with partner agencies and where appropriate, service users.
Have a shared responsibility framework with other services and clear processes in place within each service for dealing with disputes or grievances.
Regularly meet with other services to discuss how to best support victim-survivors, including children, and appropriately share information to enable comprehensive risk assessment and consideration of matters relating to the safety and wellbeing of victim-survivors with their consent.
When co-case managing or working collaboratively with a victim-survivor, the service ensures there is an action plan that documents the roles and responsibilities of each service. The action plan is reviewed regularly to ensure it is responding to the needs of the victim-survivor and the service uses advocacy approaches when client outcomes are not improving or services are not meeting their responsibilities.
Have strong links and referral processes and pathways with partner services including youth services, multicultural services, services that specialise in working with people with disability and LGBTIQA+ specialist services.

To align with this practice guideline, the service should:
Develop tools and supports which build a victim-survivor's capacity, including people and practices to enable supported decision-making.
Develop genuine connections with Aboriginal and/or Torres Strait Islander services, Elders and communities to create the best conditions for effective service delivery.
Request expert input from other services, and offer expert input to other services, to support delivery of inclusive and culturally safe responses to victim-survivors.

To align with this practice guideline, the practitioner should:
Be skilled in client focused case conferencing, co-case manage victim-survivors and, where appropriate, share information on a case-by-case basis (subject to the requirements of the privacy legislation).
Make facilitated referrals that are child-aware and parent-sensitive, with the informed consent of victim-survivors and support the victim-survivor to overcome any barriers to engagement.
Provide referrals for after hours or weekend services victim-survivors may require.
When co-case managing or working collaboratively with a victim-survivor, practitioners should be willing to sacrifice their professional autonomy for the goal of unity and be open to changing organisational practice or operational procedures to meet the aims of the joint response.

Online Resource Toolkit: Principle 7



Principle 8: Upholding and advocating for victim-survivor rights

- **Services and practitioners advance the rights and interests of victim-survivors at an individual level in a victim-survivor centred manner that is culturally safe.**
- **Services acknowledge systemic issues and work to influence policy and legislation to uphold the rights of, and improve responses to, victim-survivors of DFV and those at risk.**

DFV services advocate for the needs and rights of victim-survivors at the individual, social and political levels. This is a core part of specialist DFV practice and is closely connected with other Principles, including trauma-informed practice, victim-survivor centred practice and collaboration.

Victim-survivor rights

Practitioners must assist victim-survivors to identify their own needs and rights and to determine if their rights are being infringed or are not being met. Services will inform victim-survivors of the NSW Charter of Victims' Rights, and will have a copy available so that the services' own obligations to articulate and promote the rights of the victim-survivor is clear.

Practitioners must promote and uphold the rights of victim-survivors and their children, including their right to:

- self-determination
- positive physical, social and emotional wellbeing participate in cultural practices
- independence
- safe housing
- access support services regardless of their background, ethnicity, gender, disability, sexuality, religion or culture.

A victim-survivor may require support to identify their needs and rights and whether they are being met, particularly when there is significant trauma. Victim-survivors should be given clear information about the services they receive and the options they have within those services to help them identify if their needs and rights are being met.

Advocating for victim-survivors

At an individual level, advocacy helps a victim-survivor identify their rights and needs. Practitioners advocate to ensure the victim-survivor has access to, and assistance with, navigating the complexities of the justice and human service systems. Advocacy can only occur under the instruction of the victim-survivor and with their explicit consent. At all times the individual needs of victim-survivors and their children should be at the forefront of advocacy approaches. Advocacy must be culturally safe, respectful and collaborative.

Services build relationships with other key stakeholders and agencies to better advocate for their clients. Advocacy can be passionate and should always be professional and respectful, to ensure the DFV service has an ongoing relationship with the service or agency to which they are advocating. The client's needs should always be centred.

When undertaking systems advocacy, practitioners must be mindful of the broader context of the issues faced by their services and the victim-survivors they support, for example, experiences of racism, poor results in family court or lack of access to income support.

Data collection is an important aspect of effective systems advocacy work as it can contribute to the evidence base on good practice responses and DFV policy. When data is collected and analysed on a local and state-wide level across service systems

it strengthens advocacy efforts, thereby improving responses to DFV and helping achieve better outcomes for victim-survivors.

Effective data collection and analysis can highlight service gaps, for example, a lack of free mental health support groups in a region. Data analysis can also assist in identifying barriers to access and measures that might be taken to address those barriers.

Ongoing data analysis facilitates continuous quality improvement. It is recommended services maintain clinical practice improvement systems or quality assurance processes.

It is also good practice for services and practitioners to contribute to research projects and inquiries coordinated by government, industry bodies, peak bodies, and research agencies such as universities. This helps build an evidence base to inform DFV policy and practice. Participating in advocacy can be a way of mitigating vicarious trauma.

Advocating for all victim-survivors

Advocating for victim-survivor rights must be inclusive of all victim-survivors needs. Advocacy needs to include the experiences and perspectives of children, Aboriginal and/or Torres Strait Islanders, people living with disability, LGBTIQA+ people, people from migrant and refugee backgrounds and faith-based communities.

Advocacy also needs to be culturally safe and highlight the nuances of how communities interact and how practice and policy changes can impact on communities. Advocating for the rights of victim-survivors from a specific community should not diminish or discount the rights of victim-survivors from other communities. Advocacy should always be evidence-based.

Guideline 8.1:

Services and practitioners advance the rights and interests of victim-survivors at an individual level in a victim-survivor centred manner that is culturally safe.

To align with this practice guideline, the service should:	To align with this practice guideline, the practitioner should:
Build professional relationships with other key stakeholders and agencies to ensure good relationships are in place to address any issues for clients.	Advocate on an individual basis for victim-survivors, as well as advocating to enhance the systems that work to prevent and respond to DFV.
Have an up-to-date referral list and referral procedures to support individual advocacy.	Use strengths-based and empowering approaches to assist the victim-survivor to advocate for themselves and/or their children and only advocate on behalf of the victim-survivor with their explicit consent.
Attend interagencies where appropriate and available.	Develop and implement support plans with the victim-survivor that promote their right to live safely and any other rights and needs the victim-survivor identifies.
	Ensure the service reviews the victim-survivors' experience of services they are referred to.

Guideline 8.2:

Services acknowledge systemic issues and work to influence policy and legislation to uphold the rights of, and improve responses to, victim-survivors of DFV and those at risk.

To align with this practice guideline, the service should:	To align with this practice guideline, the practitioner should:
Participate in research and policy reforms wherever possible and relevant, including responding to relevant discussion papers and submissions.	Be capable of identifying and articulating systemic issues that impact victim-survivors of DFV.
Collect accurate data and share aggregate and anonymised data to inform policy and practice.	Ensure policies, procedures and practice are in the best interests of victim-survivors of DFV and identify when this does not occur.
Work towards shared outcomes across the human services sector to improve the way evidence, research, and data are embedded in policy and programs to achieve change and enhance learning and evaluation to improve practice.	
Ensure policies, procedures and practice are in the best interests of victim-survivors of DFV and identify when this does not occur.	
Support victim-survivors who want to advocate for change in the service or the DFV sector more broadly.	
Work collaboratively with other agencies to push for systemic changes that will improve the lives of those impacted by DFV.	

Online Resource Toolkit: Principle 8

Principle Nine

Principle 9: Prevention

Services participate in activities that tackle the drivers of DFV and promote perpetrator accountability for violence prevention.

Services address DFV by working across four broad approaches or categories: primary prevention, early intervention (also known as secondary prevention), response (also known as tertiary prevention) and recovery. These approaches have different aims and activities but can overlap in practice. All are important elements of DFV service provision, and all are critical to ending DFV.

Domestic violence is preventable. Our Watch's Change the Story framework highlight the gendered drivers of violence against women. By actively addressing these as a whole community approach we can create sustainable change. The four drives are violence against women are:

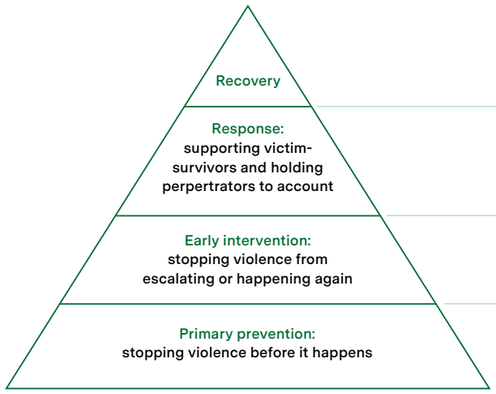
1. Condoning of violence against women
2. Men's control of decision-making and limits to women's independence in public and private life
3. Rigid gender stereotyping and dominant forms of masculinity
4. Male peer relations and cultures of masculinity that emphasise aggression, dominance, and control

Primary prevention: stopping violence before it happens

Primary prevention activities aim to stop gendered violence before it occurs by addressing the underlying drivers of gendered violence. It focuses on influencing laws, policies and the attitudes and behaviours of individuals, groups and organisations that drive and normalise violence against women and/or LGBTIQA+ people. Primary prevention activities take a 'whole-of-society' approach by working across the community in multiple settings to reach as many people as possible.

Examples of primary prevention include:

- Respectful relationships education in schools.
- Comprehensive public education campaigns.
- Workplace initiatives to promote positive bystander responses.[84]



Recovery is a continuous process that enables victim–survivors to find safety, wellbeing, resilience and to thrive in all areas of their

Response supports victim-survivors who are living with DFV or have experienced it. Response activities also target perpetrators to prevent further violence[1]. By reducing the perpetration and experience of violence, these activities directly support prevention and early intervention.

Early intervention activities target individuals, groups and environments identified as being at a higher risk of perpetrating or experiencing violence.

Primary prevention activities aim to stop gendered violence before it occurs by addressing the underlying drivers of gendered violence. It take a 'whole-ofsociety' approach by working across the community in multiple settings to reach as many people as possible.

Adapted from Our Watch Change the Story.

[84] Our Watch 2021b, Our Watch 2017

Early intervention: stopping violence from escalating or happening again

Early intervention activities target individuals, groups and environments identified as being at a higher risk of perpetrating or experiencing violence.

Early intervention activities aim to stop early signs of violence from escalating or preventing violence from happening again.[85]

Examples of early intervention include:[86]

- School programs targeting young boys who are displaying sexist behaviour and disrespectful attitudes to women and girls.
- Providing information and training on DFV to people who are at a higher risk of experiencing violence (e.g. new mothers) or professionals working with them.

Response: supporting victim-survivors and holding perpetrators to account

Response supports victim-survivors who are living with DFV or have experienced it. Response activities also target perpetrators to prevent further violence.[87] By reducing the perpetration and experience of violence, these activities directly support prevention and early intervention.

Examples of response includes:[88]

- Providing case management support, including arranging crisis accommodation, advocating for women navigating the legal and/or human services systems, providing referrals. Men's Family Violence interventions including Men's Behaviour Change Programs.
- Therapeutic programs or counselling.

State and national primary prevention and early intervention strategies and frameworks

The Good Practice Guidelines complement national and state frameworks and strategies guiding primary prevention and early intervention. DFV services should consult these frameworks and strategies for additional guidance on best practice in prevention and early intervention:

- Change the Story
- Changing the Picture
- Pride in Prevention

These and other primary prevention resources are available in the Online Resource Toolkit.

In the past, many DFV services within NSW were primarily funded to respond to violence. Services, like all individuals and organisations in Australia, should consider what primary prevention initiatives they can undertake alongside the response work they do.

Best practice services are engaged in community activities and awareness-raising initiatives that support DFV prevention and tackle the behaviours and attitudes that underpin gender-based violence. These services aim to improve public awareness of the seriousness of DFV, work to change cultural and community beliefs, attitudes and behaviour and respond to those at risk as early as possible.

Collaboration between services, government and the community and a commitment to jointly tackle the root causes of gender inequality and gender-based violence are key to successful DFV prevention and early intervention.[89]

[85] Our Watch 2021b
[86] Partners in Prevention
[87] Our Watch 2021b
[88] Domestic Violence Resource Centre Victoria, 2019
[89] Our Watch 2021b

An intersectional feminist lens that takes into account how intersecting forms of discrimination drive DFV is important to the effective prevention and early intervention of DFV. Challenging the stigmas and stereotypes that lead to systemic discrimination will make prevention and early intervention efforts more inclusive, accessible and effective.[90]

DFV services working to good practice collaborate and partner with specialist prevention and early intervention services that are tailored to diverse communities. Practitioners need a thorough understanding of family structures, relationships and experiences of abuse in diverse communities.

The primary prevention section of the Online Resource Toolkit has resources to help services better support primary prevention and early intervention with Aboriginal and/or Torres Strait Islander people, people from migrant backgrounds and faith-based communities, people living with disabilities and LGBTIQA+ people.

[90] Women NSW, 2017; Our Watch, 2021

Case study
Lou's Place

Lou's Place is a daytime women's drop-in centre in Redfern and has been operating in Inner Sydney since 1999. Lou's is a safe supportive place for all women in need, to help women heal, find community and rebuild their lives. Lou's Place offer victim-survivors case management, psychotherapeutic groups, arts and health-based wellbeing workshops and a place to access showers, meals or to meet their other basic needs.

Lou's Place focuses on being a low barrier service, with the aim of meeting women wherever they are in their life journey.

Any adult that identifies as a woman is eligible to access Lou's Place. There are no restrictions on the geographic location of clients and no length of time they are expected to engage with the service. Women can access Lou's Place in multiple ways, including self-referral, and can enter and exit as they please. This supports women to access the services they want, an approach that prioritises choice and empowerment so women can make a decision about what is right for them.

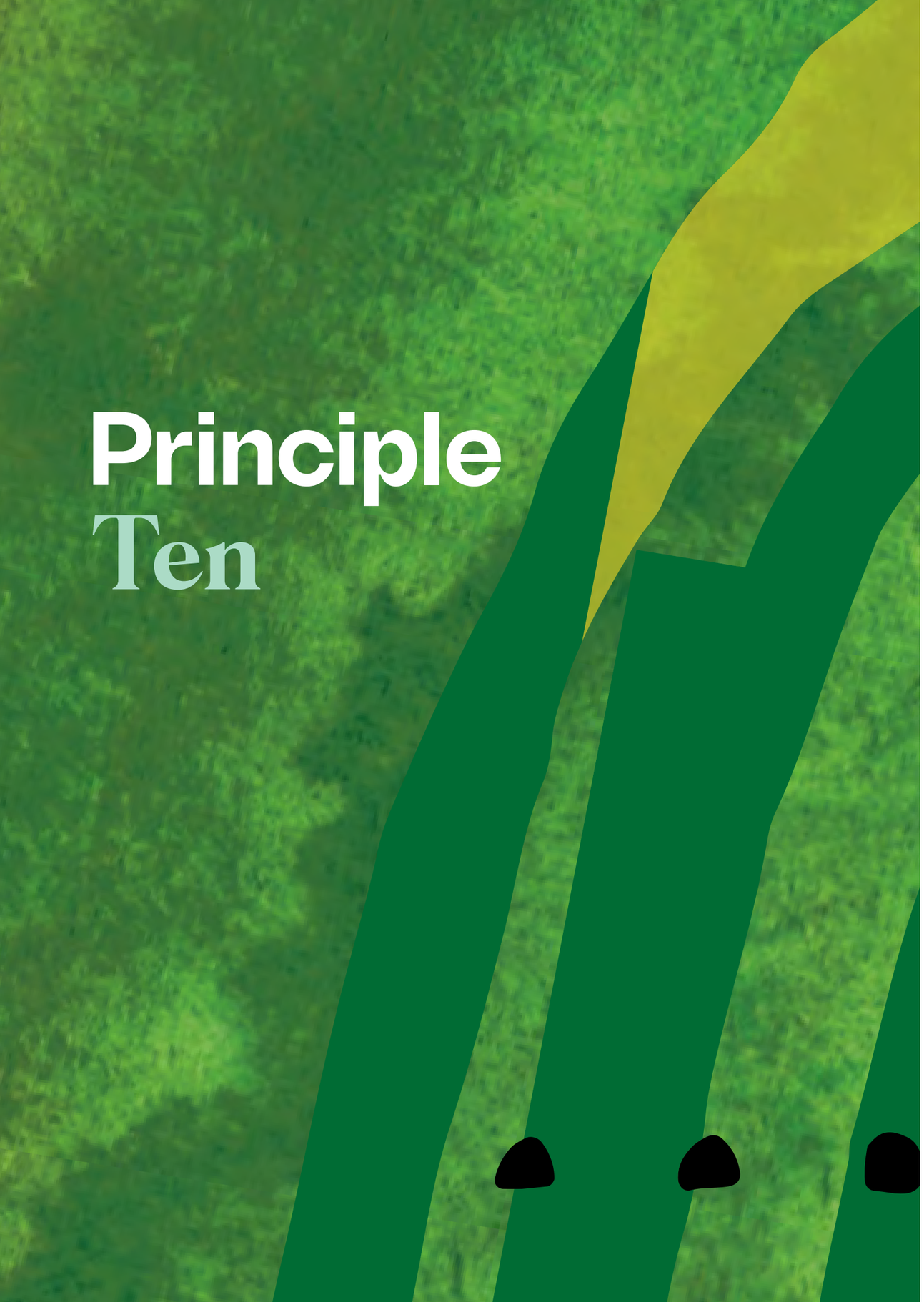
Lou's Place reaches diverse groups of women with complex and intersecting needs including women with complex mental health issues, women actively using, trans women, women on temporary visas, Aboriginal and Torres Strait Islander women and culturally, linguistically and spiritually diverse women. Lavender Bates, Case Manager at Lou's Place explains the ethos underpinning their victim-survivor centred practice: "Women are the experts and we are the resource; we are not there to judge or give advice. Our work with women is a collaboration and education".

Guideline 9.1:
Services participate in activities that tackle the root causes of DFV and promote perpetrator accountability for violence prevention.

To align with this practice guideline, the service should:
Align with the principles underpinning prevention of men's violence against women outlined in Change the Story and Changing the Picture.
Align with the principles underpinning prevention of violence against LGBTIQA+ people outlined in Pride in Prevention.
Ensure internal organisational policies and practice are aligned with primary prevention initiatives and address the gendered drivers of violence.
Develop, promote and implement strategies to raise community awareness about DFV including awareness of the impact of DFV on children.
Lead and actively participate in community activities that promote prevention of DFV and address gender inequality.
Work closely and continuously with educational institutions, community groups, individuals and lived expertise to build their trust and credibility and gain their consent in working with them to improve responses to early intervention and prevention.
Embed intersectionality in prevention and early intervention practices, ensuring strategies are tailored to the diverse needs of the community and do not further stigmatise the communities they work with.

To align with this practice guideline, the practitioner should:
Commit to building their knowledge and understanding of relationships and experiences of DFV in their local community to improve the effectiveness of interventions.
Promote positive and healthy relationships, and promote programs on the importance of those relationships, especially to young people.

Online Resource Toolkit: Principle 9



Principle Ten

Principle 10: Competency, accountability and continuous improvement

- Practitioners have the skills and training to work effectively with victim-survivors of DFV.
- Services demonstrate accountability to victim-survivors by monitoring, evaluating and continuously improving practice.
- Services support practitioners by providing a positive and empowering work environment, training and inducting new staff, and embedding practices for professional development.
- The organisation has strong governance which delivers sustainable accountable, transparent and responsive services in addition to ensuring legislative, regulatory, and funding compliance.

Victim-survivors have a right to access quality services. A capable workforce, supported by organisations with quality governance and leadership, is key to delivering quality and consistent DFV services.

Workforce qualifications and skills

Services specialising in DFV need to clearly define the roles and responsibilities of practitioners and recruit staff with appropriate expertise and qualifications. For example, a case practitioner will have formal case management qualifications and experience, while a support practitioner may have a lower level of qualifications, less experience and may have undertaken specific training to be qualified for the role.

Practitioners need baseline competencies and opportunities to develop their practice and specialist skills through ongoing training and professional development. At a minimum, practitioners should complete DV601: Practical skills in responding to people who experience domestic and family violence with ECAV or a similar course that aligns to two units of competency in the CHC Community Services Training Package:

- CHCDFV001: Recognise and respond appropriately to DFV.
- CHCDFV012: Make safety plans with people who have been subjected to DFV.

***SHS providers** should note the alignment between this principle and ASES Principles:*

- *Clear direction and accountability*
- *Continuous learning and innovation*
- *Evidence-based decision making*
- *Sound governance*
- *Strong financial and contracting stewardship*

Practitioners should also have a health or social welfare qualification at the Diploma level or higher in a relevant area, including social work, community services, counselling, psychology, welfare, youth work, disability, primary health care and/or social housing. Services should consider flexibility and acknowledgement of practice experience and lived expertise, especially for Aboriginal workers.

Experience is also highly valued in the DFV sector. It is important that services honour and value the experience an employee may have in the DFV sector while ensuring that the employee is committed to continual improvement of practice.

DFV services in NSW often have a designated intake officer to accept referrals and support new clients. The intake officer is often the first person the victim-survivor has contact with and can determine if the victim-survivor's experience with the service is positive or not. Consequently, this employee should have a nuanced understanding of DFV and excellent skills in risk analysis and trauma informed care and communication, and be child-aware and parent-sensitive.

- Organisations must be committed to ongoing professional development of staff and continuous improvement of skills and knowledge on issues relating to DFV. Employers must support this by offering practitioners time and financial support to pursue professional development opportunities, as well as having processes in place to build the capacity of staff to translate knowledge into practice.

For more guidance on the skills practitioners require, services and practitioners can also refer to the Victorian Capability Framework for Preventing and Responding to DFV.

Governance, leadership and client participation

The professionalism and effectiveness of a service is embed through good governance structures and management strategies.

Good governance ensures services have strong and relevant organisational strategies and plans. Effective operational activities, prudent regulatory compliance, thorough financial and risk management processes, structures in place to ensure staff and stakeholder engagement and communication flow increases the likelihood and degree to which an organisation delivers its purpose or achieves its mission.[91]

Services must have a well-developed and outcomes-focused strategic plan. Services working to good practice have processes in place to revise and review their practice and procedural models regularly, sharing outcomes within their networks to encourage continuous improvement and good practice.

Evaluation can support continuous improvement, help services meet reporting requirements of funders and demonstrate a commitment to victim-survivors by asking for feedback on the service provided and how it can be improved. Services can undertake periodic formal evaluations, conducted in-house or by independent researchers, to assess the effectiveness of any element of a service, including:

- The governing body and management.
- Communication, at the practitioner and service level.
- Access and equity.
- Client experience of the service and the quality of support offered.

Services undertaking evaluations should develop a process to implement evaluation recommendations and share findings with key stakeholders, including clients, to contribute to the evidence base on responses to DFV and demonstrate transparency and accountability.

Client participation as a mechanism for accountability

Lived expertise should be at the centre of all service design and delivery.

Client participation in governance, continuous improvement and strategic planning is good practice in DFV service delivery. It reflects service accountability to victim-survivors and honours the role lived expertise plays in service design and delivery.

People with lived expertise can better predict and plan for the needs of service users. When engaged in co-design or co-production, people with lived experience, also known as survivor-advocates, can build their sense of empowerment.

Services facilitating client participation should include a diverse range of victim-survivors, including children and young people, through tailored engagement strategies. At a minimum, services facilitating client participation should have systematic procedures for collecting, analysing and responding to feedback from victim-survivors. Client participation must always be ethical and safe.

[91] Australian Institute of Company Directors 2017

Guideline 10.1:
Practitioners have the skills and training to work effectively with victim-survivors of DFV.

To align with this practice guideline, the service should:
Provide staff with comprehensive training, supervision and support to ensure appropriate responses to victim-survivors.
Ensure senior staff and management should have a graduate degree in a human services-related field, or a minimum of 10 years practice experience.
If possible, establish a Senior Practitioner role.
Recruit practitioners for their knowledge, skills and experience with victim-survivors of DFV and/or working with vulnerable and at-risk people, children and communities.
Ensure new employees have a thorough orientation, adequate risk assessment and safety planning training and a developed understanding of the nature and dynamics of DFV.
Provide induction training on all policies, procedures and guidelines.
Ensure practitioners are empowered and supported if they are victim-survivors themselves e.g. confidential support strategies and DFV leave provisions.

To align with this practice guideline, the practitioner should:
Be skilled and trained in the unique risks and symptoms of DFV, for example the link between homicide and strangulation, the risks associated with acquired brain injury for victim-survivors who have experienced or are experiencing physical violence, the impact DFV can have on a child's development, the increased risk of substance misuse and post-traumatic stress disorder.
Reflect and understand their own personal triggers and how these can impact working with victim-survivors.
Understand the potential emotional impact of providing support to victim-survivors and identify and implement self-care strategies to minimise the impact.

Guideline 10.2:
Services demonstrate accountability to victim-survivors by monitoring, evaluating and continuously improving practice.

To align with this practice guideline, the service should:
Allow time for practitioners to have a regular reflective practice and clinical supervision.
Have an accessible complaints system, and review complaints regularly to improve practice.
Make service users aware of the complaints process.
Introduce robust clinical practice improvement systems or quality assurance processes.
Actively encourage feedback from service users and reflect on practice when feedback is given.
Use inclusive, accessible and relevant evaluation tools and approaches embedded within operational and project plans.
Develop partnerships with victim-survivors to help understand what is working and identify opportunities for service improvement.
Establish processes for the regular review of service policies, procedures, strategic and operational plans that actively seek the views and input from staff, victim-survivors, partner agencies and other stakeholders.
Have processes to implement evaluation recommendations and share findings with key stakeholders, including clients.
Give practitioners time to keep up to date with research, literature and good practice initiatives relating to DFV practice work.

To align with this practice guideline, the practitioner should:
Reflect on their practice and be open to change.
Actively encourage feedback from service users and reflect on practice when feedback is given.
Keep up to date with research, literature and good practice initiatives relating to DFV practice work.

Guideline 10.3:

Services support practitioners by providing a positive and empowering work environment, training and inducting new staff, and embedding practices for professional development.

To align with this practice guideline, the service should:
Make DFV leave available to staff and give staff access to support through employee assistance programs and/or external professional supervision.
Foster positive working relationships between all staff and work quickly to address any staff conflict. Promote a positive and empowering work environment and avoid infringing WHS and anti-discrimination laws.
Consider the work-life balance of staff and be open to flexible work practices.
Ensure practitioners have opportunities for training and professional development, including supervision to support and enhance their practice and work through any triggers.
Be proactive in contracting training and professional development for staff in areas where more skill or additional expertise is required.

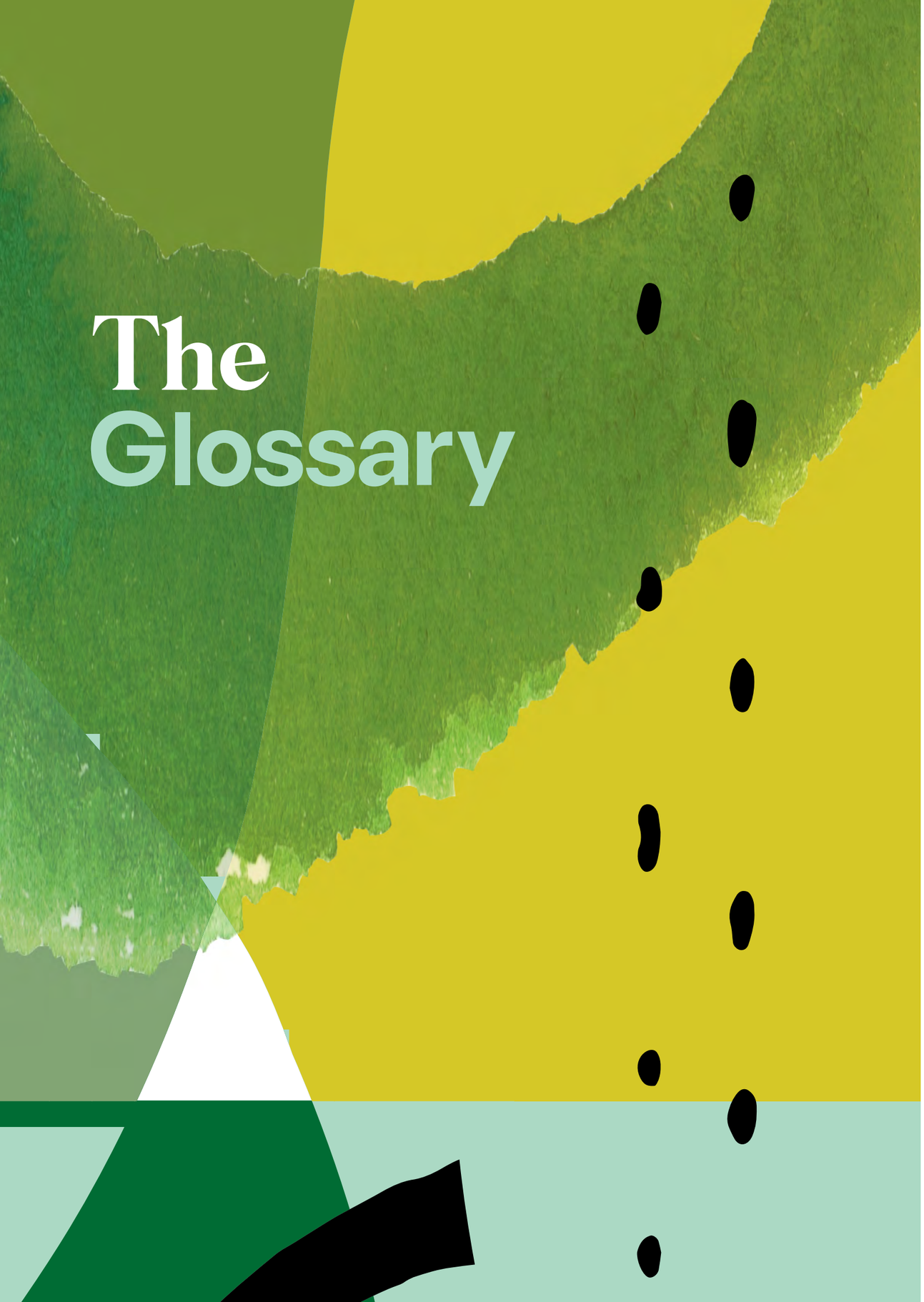
Guideline 10.4:

The organisation has strong governance which delivers sustainable accountable, transparent and responsive services in addition to ensuring legislative, regulatory and funding compliance.

To align with this practice guideline, the service should:
Be diverse and reflect the local community.
Be skills-based, with each member having specialist expertise and experience to contribute to the capability and effective functioning of the service.
Meet regularly to discuss the progress and outcomes of the service. Meetings should be conducted professionally, have an agenda and run efficiently.
Have sub-committees where appropriate.
Draw on the expertise of lived experience.
Set the tone for ethical and responsible decision making throughout the organisation, including declaring any conflicts of interest.
Treat members with respect, dignity and professionalism.

To align with this practice guideline, the practitioner should:
Have a clear vision, purpose and strategy to which all operational tasks relate
Ensure each staff member has clear roles and responsibilities.
Give staff up-to-date work plans that reflect their duties and are aligned with goals and performance indicators to determine satisfactory practice.
Frequently and transparently share information between senior management staff and the governing body, particularly relating to financial statements and other key information relating to the operational procedures of the service.
Have a systemic approach to risk identification, management, monitoring and review that is embedded in the organisation's strategic and operational planning processes and used by staff at all levels to inform decision making.
Have recruitment, induction and workforce development processes that support members of the governing body and staff (including volunteers, interns etc.) to develop an understanding of their roles and responsibilities, including legal, regulatory and funding obligations related to their positions.

Online Resource Toolkit: Principle 10



5. Glossary

Ableism
A term used to capture the way that the construction of social systems with able bodied people as the norm results in the systemic, structural, intersecting and individual forms of discrimination against, and exclusion of, people with disability.[93]

Backlash / resistance
The resistance, hostility or aggression with which gender equality or violence prevention strategies are met by some groups. From a feminist perspective, backlash can be understood as an inevitable response to challenges to male dominance, power, or status, and is often interpreted as a sign that such challenges are proving effective.[94]

Cisgender/ Cisgenderism
Cisgenderism (sometimes referred to as cisnormativity and cissexism) is a structural stigma that denies, ignores, and pathologises the trans experience and trans people – binary and non-binary. Cisgenderism positions expansive expressions of gender as a problem, ignores the validity of non-binary genders and seeks to enforce traditional gender roles and inequalities.[95]

Coercive Control
Coercive control is often a significant part of a person's experience of domestic and family violence and describes someone's use of abusive behaviours against another person over time, with the effect of establishing and maintaining power and dominance over them. Abusive behaviours that perpetrators can use as part of their pattern of abuse include physical abuse (including sexual abuse), monitoring a victim-survivor's actions, restricting a victim-survivor's freedom or independence, social abuse, using threats and intimidation, emotional or psychological abuse (including spiritual and religious abuse), financial abuse, sexual coercion, reproductive coercion, lateral violence, systems abuse, technology-facilitated abuse and animal abuse. A focus on coercive control reflects a shift from specific, isolated incidents (of primarily physical violence) to a recognition that individual acts can be used by perpetrators to form a broader pattern of abusive behaviours that reinforce and strengthen the control and dominance of one person over another.[96]

Domestic and Family Violence
Domestic and family violence (DFV) is when someone behaves abusively towards a person they are in an intimate or family relationship with. Domestic and family violence is part of a pattern of behaviour that controls or dominates a person and makes them fear for their own and/or other people's safety and wellbeing. DFV includes, but is not limited to physical violence, sexual violence, verbal abuse, emotional abuse, psychological abuse and economic abuse.

Some DFV behaviours are relevant to intersectional experiences and can occur in all types of personal or family relationships or intimate partnerships and care arrangements. It is an overarching term that includes other related terms such as intimate partner violence, elder abuse, child abuse and adolescent family violence.[97]

Gendered drivers of violence
The underlying causes that are required to create the necessary conditions in which violence against women, children and LGBTIQA+ people occurs. They relate to the particular structures, norms and practices arising from gender inequality in public and private life, but which must always be considered in the context of other forms of social discrimination and disadvantage.[98]

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[93] Department of Social Services, 2022
[94] Department of Social Services, 2022
[95] Department of Social Services, 2022
[96] Department of Social Services, 2022
[97] Domestic Violence Victoria, 2020
[98] Department of Social Services, 2022

Gender inequality
A social condition characterised by unequal value afforded to men and women and an unequal distribution of power, resources and opportunity between them. It is the direct result of patriarchal systems that privilege the needs, interests and behaviours of men over women, and that permeate many aspects of Australian society and institutions.[99]

Gender identity
A person's deeply felt sense of being male, female, both, in between, or something other.[100]

Gender stereotypes
Gender stereotypes are simplistic assumptions and generalisations about the attributes, skills, behaviours, preferences and roles that people should have or demonstrate based on their gender. These attributes are often perceived as natural or innate but are actually the result of people of different genders being socialised in different ways. Gender stereotypes are not necessarily negative assumptions or generalisations.[100]

Heteronormativity
Heteronormativity includes a suite of cultural, legal and institutional practices that work to explicitly privilege relationships between 'men' and 'women' as the only 'normal' and 'natural' form of relationship.[102]

Intergenerational trauma
A form of historical trauma transmitted across generations. Survivors of the initial experience who have not healed may pass on their trauma to further generations. In Australia, intergenerational trauma particularly affects Aboriginal and/or Torres Strait Islander people, especially the children, grandchildren and future generations of the Stolen Generations.

Intersectional approaches
Involves recognising that an experience can differ based on cultural, individual, historical, environmental, or structural factors such as race, age, geographic location, sexual orientation, ability or class. This approach also recognises that dynamics of oppression and inequalities can be confounded by other forms of oppression and inequality, resulting in some groups of people experiencing more severe forms of violence and face even more barriers to support their safety.[103]

Lived expertise
Victim-survivors have specific and contextual expertise that comes from lived experience of abuse and violence. They have intimate, firsthand knowledge of services, systems and structures that may have supported them or failed to support them. Working with those with lived expertise is essential to informing appropriate and effective initiatives.[104]

Non-binary
An umbrella term for any number of gender identities that sit within, outside of, across or between the spectrum of the male and female binary. A non-binary person might identify as gender fluid, trans masculine, trans feminine, agender, bigender, etc[105]

People with disability
Disability is a physical or mental condition that limits a person's movements, senses, or activities.

Disability results from the interaction between individuals with a physical, mental or health condition and the environment i.e. societal negative attitudes, inaccessible transportation, inaccessible buildings/built environment, and limited social support.

A person's environment has a huge effect on the experience and extent of disability. The 'disabling factor' is society and its environments, that pose barriers hindering the full and effective participation of persons with disabilities in society on an equal basis with others.[106]

[99] United Nations Committee on the Elimination of Discrimination against Women, General recommendation no. 35
[100] Department of Social Services, 2022
[101] Domestic Violence Resource Centre Victoria (DVRCV), 2019
[102] Department of Social Services, 2022
[103] Department of Social Services, 2022
[104] Department of Social Services, 2022
[105] Department of Social Services, 2022

Perpetrator or person who perpetrates violence
This term describes people and mainly men who use family violence or commit sexual violence against women. This is used regardless of whether a person has ever been arrested or charged with a crime related to this.[107] It also includes the perpetration of one or more forms of domestic and family violence including, but not limited, to coercive control, physical violence, emotional/psychological abuse and economic abuse.

Strengths-based practice
A practice that focuses on abilities, knowledge and capacities of the client rather than deficits or things they may be lacking. This involves using client-led goals, focussing on strengths, facilitating support and growth, valuing difference and collaboration and providing hope and motivation.[108]

Trauma-informed practice
Trauma-informed care and practice recognises the prevalence of trauma and its impacts on the emotional, psychological and social wellbeing of people and communities. Trauma-informed practice means integrating an understanding of past and current experiences of violence and trauma in all aspects of service delivery. The goal of trauma-informed systems is to avoid re-traumatising individuals and support safety, choice and control to promote healing.

Victim-survivors
Within these Guidelines, this term is inclusive of intersectionality's such as women with disability, Aboriginal and/or Torres Strait Islander women, women from migrant or refugee backgrounds and LGBTIQA+ people. The term is also inclusive of those who are parents and/or caregivers.

Whilst it is recognised not all victim-survivors are parents, many will be. They may be pregnant, a parent or caregiver to a child who may be in or out of their care, or become a parent or caregiver in the future.

This term is also inclusive of children who have experienced, witnessed or been exposed to the effects of DFV. It is important to note that children do not need to directly experience or witness violence or abuse to be affected by it. The term children is inclusive of all infants, toddlers and children.

[106] Disability World Health Organisation
[107] DVRCV, 2019
[108] Department of Social Services, 2022

6. Understanding domestic and family violence

Domestic and family violence is widespread and causes significant damage to victim-survivors, families and communities across Australia.

We know that, since the age of 15:[109]

At least 240 women in Australia were killed by their current or former male partner between 2010 and 2018.[110]

Domestic and family violence is the single largest driver of homelessness for women and children,[111] is a factor in many child protection cases,[112] and results in a police call- out on average once every two minutes across the country.[113] COVID-19 saw an increase in demand for DFV services.[114]

Women living with disability are two times more likely than women without disability to experience physical violence, partner violence, emotional abuse, sexual harassment, and stalking.[115] This violence extends beyond partner and family violence as it can also be experienced from a carer or service provider.

6.1 Obtaining Data on Domestic and Family Violence

DFV services should regularly access the evidence-base for detailed and up-to-date information on DFV. Most organisations offer a regular e-news which can offer up-to-date research. Key resources include:

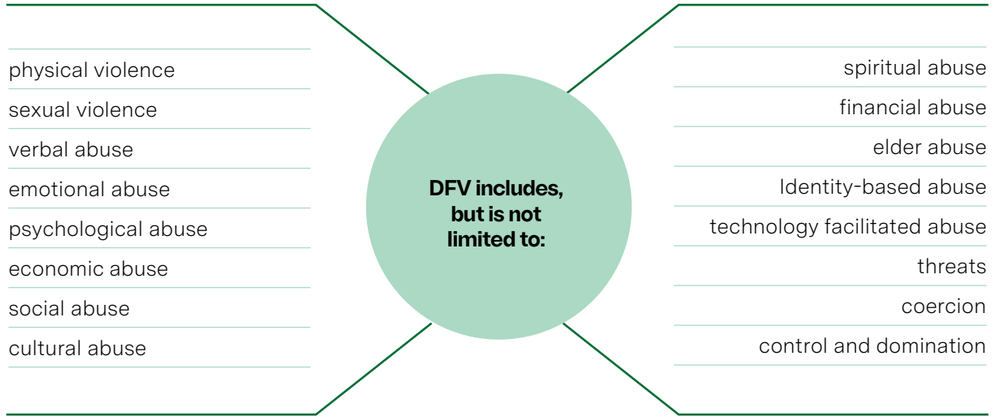
- Research from ANROWS
- Data from the Australian Bureau of Statistics
- Data and reports from the Australian Institute of Health and Welfare
- Data from the NSW Bureau of Crime Statistics and Research
- Research from La Trobe University on LGBTIQA+ DFV
- Australian Institute of Family Studies

[109] Our Watch 2021b
[110] Australian Domestic and Family Violence Death Review Network & ANROWS 2022
[111] AIHW 2019
[112] Shlonsky, Ma, Katz et al. 2017
[113] Blumer 2016
[114] McKibbin et al. 2021
[115] Australian Bureau of Statistics 2021

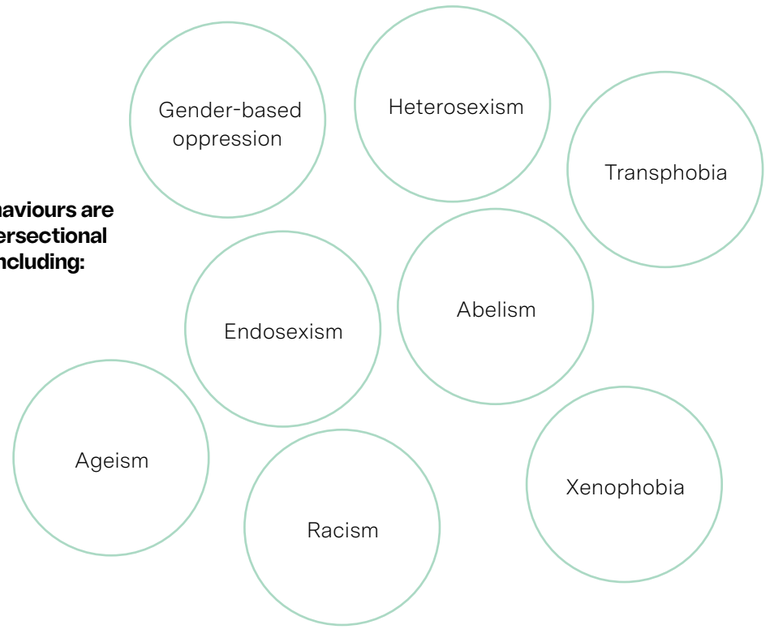
6.2 Defining Domestic and Family Violence

Domestic and family violence is when someone behaves abusively towards a person they are in an intimate or family relationship with.

Domestic and family violence is part of a pattern of behaviour that controls or dominates a person and makes them fear for their own and/or other people's safety and wellbeing.



Some DFV behaviours are relevant to intersectional experiences, including:



DFV can occur in all types of personal or family relationships or intimate partnerships and care arrangements. It is an overarching term that includes other related terms such as intimate partner violence, elder abuse, child abuse and adolescent family violence.[116]

An intimate relationship refers to people who are (or have been) in an intimate partnership, for example: partners that are married or engaged to be married, separated, divorced, de facto; couples promised to each other under cultural or religious tradition and people who are dating. An intimate relationship does not have to include a sexual relationship.

A family relationship includes people who are related to one another through blood, marriage or de facto partnerships, adoption and fostering relationships, sibling and extended family relationships. It includes cultural kinship ties and extended family and community in Aboriginal and/or Torres Strait Islander communities, extended family relationships, families of choice for LGBTIQA+ people, people living in the same house, paid or unpaid carers for people living with disability and people living in the same residential care facility.[117]

6.3 Impact of Domestic and Family Violence

DFV can have serious and long-lasting impacts on the victim-survivor:

- DFV is a leading contributor to death, injury and illness among Australian women aged 18-44. [118]
- DFV is the main reason women and children leave their home in Australia and is one of the most common reasons clients seek assistance from Specialist Homelessness Services.[119]
- Economic insecurity due to factors such as the perpetrator refusing access to finances, absence from work, private legal costs, perpetrator not paying child support post-separation.[120]
- Physical and psychological harm including depressive disorders, anxiety, early pregnancy loss, self-inflicted injuries and suicide, disorders associated with alcohol use.[121]
- Severe, pervasive and lifelong effects on victim-survivor health, identity, relationships, expectations of themselves and others, emotional regulation and world view.[122]

DFV also has an impact on the community and economy. The combined health, administration and social welfare costs of violence against women in Australia is conservatively estimated to be $22 billion in 2015-16.[123]

The underrepresentation of Aboriginal and/or Torres Strait Islander women, pregnant women, women with disability and women who are homeless in national statistics on women's experiences of violence may add $4 billion to the estimated cost of violence against women and their children in Australia.[124]

6.4 Impact on Children and Young People

Infants, children and young people who have experienced or witnessed DFV or have been exposed to the effects of DFV are victim-survivors in their own right. DFV is a violation of their human rights.

Responses to DFV need to consider the diverse impacts DFV has on children and young people and what is needed for their recovery, including therapeutic responses.[125] DFV services must recognise children and young people as clients in their own right, be child-centred and directly engage children and young people in service provision when safe and reasonable to do so.

DFV services must meet the Child Safe Standards and the National Principles for Child Safe Organsations; these frameworks help services create child safe organisational cultures that keep children from harm and ensure their wellbeing. This includes specialised skills and training for staff working with children and young people.

DFV can have immediate and long-term impacts on children and young people, including:

- Neurodevelopmental impacts on emotional regulation, behaviour, stress responses and interactions with others.[126]
- Physical injury, sexual abuse, neglect and death.[127]
- Psychological and emotional trauma.[128]
- Homelessness.[129]
- Worse health, social and educational outcomes than children in families without parental conflict.[130]
- Using or experiencing DFV later in life.[131]
- Contact with the youth justice system and adult criminal conduct.[132]

DFV can significantly impact the relationship between a parent/carer who is a victim-survivor of DFV and their child/children. The perpetrator may use tactics to disrupt the relationship and erode the parenting capacity of the adult victim-survivor.[133] Interventions to strengthen the relationship between the parent/carer victim-survivor and their children and enhance parenting capacity are critical to helping children recover from trauma.[134]

Children and young people have a diversity of experiences of DFV that can be influenced and compounded by multiple intersecting factors. An intersectional approach is critical to supporting children and young people.

DFV also has varying impacts on children and young people depending on their life stage. Exposure to violence in pregnancy has been linked to low birthweight in infants, pregnancy loss, pre-term labour and perinatal morbidity.[135]

Exposure to DFV during adolescence and young adulthood can intersect with other factors such as gaining employment and forming intimate relationships, making them more vulnerable to poor outcomes in mental and sexual health, housing and employment.[136] Young people may also take on caring responsibilities, such as looking after younger siblings.[137]

Young people who have been impacted by DFV may present at youth refuges or youth-specific services. These services must have a thorough understanding of DFV, undertake appropriate risk assessments to ensure safety for the young person and work closely with DFV specialist services.

[116] Domestic Violence Victoria 2020
[117] Women NSW, 2014
[118] Webster, 2016
[119] Spinney, 2012
[120] Kaspiew et al. 2017; PriceWaterhouseCoopers, 2015
[121] Australian Institute of Health and Welfare, 2019
[122] Elliott et al. 2005
[123] KPMG, 2016
[124] KPMG, 2016
[125] Family Safety Victoria, 2017
[126] Perry et al. 1995
[127] Australian Institute of Health and Welfare 2019; Royal Commission into Family Violence, 2016
[128] Royal Commission into Family Violence, 2016
[129] Royal Commission into Family Violence, 2016
[130] Kaspiew et al. 2017; Royal Commission into Family Violence, 2016
[131] Royal Commission into Family Violence, 2016
[132] Royal Commission into Family Violence, 2016
[133] Hooker, Kaspiew, & Taft, 2016
[134] Hooker, Kaspiew, & Taft, 2016
[135] Bunston & Sketchley, 2012
[136] Royal Commission into Family Violence, 2016
[137] Royal Commission into Family Violence, 2016

6.5 Barriers to Accessing Support for Domestic and Family Violence

Victim-survivors face barriers to accessing DFV services at the individual, service and societal levels. Sometimes, these barriers are a result of the DFV the victim-survivor has experienced.

The trauma of DFV can impact on a victim-survivor's identity and worldview, creating barriers such as shame, guilt, low-self-esteem, and normalisation of violence.[138] Experiencing violence can also create barriers to accessing support, for example a perpetrator may limit a victim-survivors access to the phone and internet and/or monitor their usage.

Victim-survivors may fear reprisal or escalating violence from the perpetrator if they are seen accessing a service. They may fear being disbelieved or blamed and possible exclusion or persecution from their community and can be a barrier to disclosing violence. This is especially relevant for people from migrant and refugee backgrounds and faith-based communities, LGBTIQA+ people and Aboriginal and/or Torres Strait Islander people.[139]

Marginalised victim-survivors experience systemic barriers to accessing support, including LGBTIQA+ people, Aboriginal and/or Torres Strait Islander people, people from migrant and refugee backgrounds and faith-based communities, people living with disability and people from regional, rural and remote areas. This can include discrimination, geographic constraints and physical access issues, communication barriers and insufficient service provision to meet demand. Children and young people face multiple barriers accessing services, including unavailability of services for children and young people presenting independently of an adult victim-survivor.[140]

Inequality and discrimination can create and amplify barriers and an intersectional approach is critical to creating an equitable and accessible service.[141]

For Aboriginal and/or Torres Strait Islander victim-survivors, fear and distrust may result from the impacts of colonisation and the operation of mainstream authorities and justice systems as agents of oppression.[142] Other agencies such as health and welfare services may be regarded with distrust and experienced as being racist, authoritarian or sexist.[143]

Government practices that harm Aboriginal and/or Torres Strait Islander women and children, such as the removal of Aboriginal and/or Torres Strait Islander children, still happen at unacceptable rates and perpetuate an ongoing fear that if women experiencing domestic and family violence disclose and seek assistance, they may have their children removed.[144]

In addition to these barriers, services should also consider:

- Fear of revictimisation through legal processes, which can be confronting, invasive and traumatic for victim-survivors.[145]
- Difficulty maintaining anonymity for victim-survivors living in small, interconnected and isolated communities.[146]
- The role of the service and its practitioners in creating/maintaining barriers for victim-survivors, using intersectionality as a tool for reflective practice.

[138] Heron & Eisma, 2021
[139] El-Murr 2018; Pride in Diversity 2018; Willis 2011
[140] Family Safety Victoria 2019
[141] Family Safety Victoria 2019
[142] Willis 2011; Putt, Holder & O'Leary 2015
[143] Putt, Holder & O'Leary 2015
[144] Willis 2011; Putt, Holder & O'Leary 2015
[145] Lievore 2003; see also Willis 2011 for details on how this impacts Aboriginal and/or Torres Strait Islander women
[146] Willis 2011

- Developing networks and appropriate referral pathways with specialist services to help meet victim-survivor needs.[147]

There are also a range of pragmatic barriers victim-survivors may face that services need to anticipate and respond to.

Useful actions to address barriers accessing support include:

- **Communication**
  - Staff training on access and inclusion.
  - Making service information (e.g. websites, posters and pamphlets) available in easy English and key community languages.
  - Providing alternative communication methods to support people with disability.
  - Service information should showcase the National Interpreter Symbol, Aboriginal and Torres Strait Islander flags and Pride flags to indicate they are culturally safe.
  - Not use children or other relatives as interpreters.
- **Income**
  - Supporting victim-survivors to navigate Centrelink and immigration rights and entitlements. This is very difficult and time-consuming work which requires detailed understanding of the systems and trauma-specialist skills.
- **Pets**
  - Accommodation services are urged to consider providing accommodation where victim-survivors are able to bring pets with them.
  - At a minimum, services should have contacts with their local animal shelter who will often care for the pet temporarily or can arrange foster care (such as the RSPCA's Community Domestic Violence Program).
- **Physical location of the service**
  - Services and practitioners may offer casework and support over the phone or online (if safe phone/internet access is available and reliable) or undertake outreach work where feasible and safe to do so.
  - The service is accessible for people living with disability, see the Building Access project on ways to make services more accessible.

[147] Domestic Violence Victoria 2020

7. Practice Standards and the Policy Context - NSW and Australia

The Good Practice Guidelines were written in collaboration with the Men's Behaviour Change sector and were designed to complement the NSW Practice Standards for Men's Domestic Violence Behaviour Change Programs.

The Good Practice Guidelines sit alongside a range of good practice guides developed by the NSW Specialist Homelessness Services Industry Partnership to assist with helping achieve best outcomes for organisations and clients:

- Practice Guidelines for SHS utilising National Disability Insurance Scheme
- Good Practice Guidelines for working with Unaccompanied Children
- Assertive Outreach Good Practice Guidelines and Resources
- LGBTIQA+ Inclusive Practice Guide for Homelessness
- Industry Partnership Good Practice Guides

7.1 ASES accreditation and the Good Practice Guidelines

The Good Practice Guidelines meet the Australian Service Excellence Standards (ASES), a set of standards and a quality improvement program that aims to assist non-government organisations to improve their business systems, management practices and service delivery. SHS providers funded by the Department of Communities and Justice need ASES accreditation by June 2024.

Some DFV service providers are also SHS providers. DFV providers working towards ASES accreditation should first meet the ASES standards and then work towards additional guidelines and standards to avoid undue work and duplication. The Good Practice Guidelines meet ASES principles, detailed in Table 1.

DFV service providers that are not SHS providers should work towards compliance with the Good Practice Guidelines.

The Good Practice Guidelines align with practice standards across other jurisdictions, including:

- Victorian Victorian Code of Practice: Principles and Standards for Specialist Family Violence Services for Victim-Survivors
- Queensland Government Practice Standards for the DFV Sector
- Western Australian Practice Guidelines: Women and Children's FDV Counselling and Support Programs
- ACT Domestic and Family Violence Risk Assessment and Management Framework
- NT Domestic and Family Violence Risk Assessment and Management Framework
- Plan4womenssafety.dss.gov.au.

The domestic and family violence policy context for the Good Practice Guidelines includes:

- NSW Health Strategy for Preventing and Responding to Domestic and Family Violence 2021-2026
- Primary prevention tools and research of Our Watch
- Closing the Gap
- NSW Women's Strategy
- The National Plan to End Violence against Women and Children 2022-2032
- The standalone Aboriginal and Torres Strait Islander Women's National Plan to End Violence against Women and Children (2023-2032).
- The NSW Domestic and Family Violence Plan 2022-2027 (forthcoming)
- The NSW Sexual Violence Plan 2022-2027 (forthcoming)
- The NSW Primary Prevention Plan (forthcoming).

Table 1: Good Practice Guidelines compliance with Australian Service Excellence Standards (ASES)

ASES Principles	Domestic Violence NSW Good Practice Guideline
Customer and outcome focused	Foundational concepts
	Principle 4
Clear direction and accountability	Principle 10, Guideline 10.4
Continuous learning and innovation	Principle 10, Guideline 10.1
	Training is incorporated into every guideline, principle and each level of practice and service care
Valuing people and diversity	Foundational concepts
	Principle 2
	Principle 6
Collaborative work practices	Principle 7
Evidence-based decision making	Principle 10, Guideline 10.2
Social, environmental and ethical responsibility	Foundational concepts
	Principle 2
Sound governance	Principle 10
Strong financial and contracting stewardship	Principle 10, Guideline 10.4

8. References

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