"Quality is never an accident; it is always the result of high intention, sincere effort, intelligent direction and skillful execution; it represents the wise choice of many alternatives." – William A. Foster, U.S. Marine & Medal of Honor recipient

DEVELOPING MINIMUM STANDARDS FOR DVSA SERVICE IN AMERICAN SAMOA

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Defining Minimum Standards

The 'Standard' is the minimum benchmark for the conduct, performance, knowledge requirements, service provision and quality of services provided to DVSA victims[19]. Each standard should be based on underlying principles which validate its requisite for performance.

The **purpose of developing Minimum Standards for Domestic Violence and Sexual Assault Services[6]** is

1 – to establish a minimum level of expectation by victims;

2 – hold everyone in the service system accountable to these standards to ensure appropriate assistance and services are provided in ways that uphold and demonstrate human dignity and fairness;

3 – empower victims with necessary information to enable them to enforce their rights;

4 – to make monitoring of service delivery easier by setting out minimum standards against which it will be measured.

Generally accepted national and international standards for DVSA services reflect principles of justice, safety, trust, choice, collaboration, empowerment and cultural competency for victims of DVSA, laying a foundation upon which guidelines and benchmarks for legal, clinical, and social service frameworks may be developed. The needs of DVSA victims are unique to the culture and environment of a people. The way in which services should, and could, be provided is also unique to the economic, political and environmental contexts of the community served. Therefore, the minimum standards in American Samoa should reflect these variables accordingly.

The United Nations' Declaration of the Basic Principles of Justice for Victims of Crime and Abuse of Power to which the U.S. is a signatory, **defines a victim of crime** as:

A person who has suffered harm, including physical or mental injury, emotional suffering, economic loss or substantial impairment of his or her fundamental rights through acts or omissions that are in violation of our criminal law. The term 'victim' also includes the immediate family or dependents of the direct victim. A person may be considered a victim regardless of whether the perpetrator is identified, apprehended, prosecuted, or convicted and regardless of the familial relationship between the perpetrator and the victim.

Minimum Standards are applicable to all victims without prejudice of any kind on the grounds of race, gender, sex, pregnancy, marital status, ethnic or social origin, color, sexual orientation, age, disability, religion, conscience, belief, culture, language and birth as enumerated in the U.S. Constitution – Bill of Rights. These rights also represent **principles behind the minimum standards of service provision** for victims of DVSA. Specifically, victims of violence and sexual assault have the following rights:

The right to be treated with fairness and with respect for dignity and privacy;
The right to offer information;
The right to receive information;
The right to protection;
The right to assistance;
The right to compensation;
The right to restitution (justice).

The Development Process

Background

The **American Samoa Alliance Against Domestic Violence and Sexual Assault** (aka Alliance) is one of 56 national Coalitions recognized by the federal Office for Victims of Crime – Victims of Crime Act (VOCA), and the Office on Violence Against Women – Violence Against Women Act (OVW). The Coalitions are exclusively funded membership organizations for local service providers and advocates for improvements in laws, services and resources for victims of domestic and sexual crimes. As such, they have a fiduciary duty to effectively participate in the development of the territory's response to domestic violence and sexual assault (DVSA).

Community Context

The Alliance is conducting an ongoing assessment of territorial DVSA service provision levels and standards, and the coordinated response mechanisms used by service providers. Preliminary research shows that to date there is no intent to develop a 'State Plan' to include an organized response to DVSA, there are no Coordinated Community Response (CCR) teams, or Sexual Assault Response Teams (SART); nor is there a Sexual Assault Crisis Center or any semblance of an organized network of service providers.

A minimal level of service i.e. Child Protective Services, Rape Kits, one emergency shelter, are provided through the federally funded Department of Human and Social Services. However, interviews with service providers reveal that first responders, including LBJ Hospital and Department of Safety (police), operate in 'silos' without protocols for referral, transfer, or inter-agency case management. A consistent theme reported across key informant interviews (*see Methodology, p. 3*) is the lack of communication and coordination between government departments, between these departments and community councils and non-profit service providers, and the public. There is no tracking or referral system between departments, resulting in duplication of efforts and victims lost to follow up. Departments are in competition with each other for funding mechanisms and reluctant to share data.

The preliminary assessment also reveals that core services for victims (Figure A) of sexual assault are not available in American Samoa. The interviews and surveys with stakeholders reflect a lack of understanding of what the core services provide victims/survivors, and that there are few services available for some of the most vulnerable individuals in our population including children, females, the disabled and elderly. (See '*Rape Crisis Center Feasibility Study* 2018', Alliance Against Domestic Assault & Sexual Violence). This led to the need to conduct research to support a proposal of Minimum Standards for DVSA services and protocols in American Samoa.

Methodology

In 2018, the Alliance completed the Rape Crises Center Feasibility Study and commenced the DVSA Gap Assessment utilizing a community based participatory-action model of qualitative research. The goal is determine the feasibility of developing a coordinated community response to the unique needs of local SA victims in the multiple contexts of service delivery in American Samoa including culture, place, literacy and economics.

The Alliance conducted interviews with 19 community leaders, and 10 SA survivors. They also surveyed 42 individuals from member organizations, 19 community leaders and 10 SA survivors. In addition to identifying the strengths, limitations, and gaps in the existing service delivery protocols the Alliance aimed to define the needs of member organizations and the community to effectively serve victims/survivors of SA. Interview questions and surveys were reviewed by a group of Samoans familiar with the Samoan language and culture, and pre-tested before interviews and surveys were completed on July 30th, 2018.

To develop Minimum Standards for DVSA services and protocols in American Samoa the Alliance conducted desk-based research to tabulate proposals for standards from human rights documentation, existing best practices and adopted standards. A literature review was conducted using references linked to websites and publications relevant to DVSA research to identify minimum standards for service provision and operation in the U.S. and abroad. The literary research process was guided by the thematic analysis from the stakeholder survey responses and key informant interview analysis.

Literature Review

The first aim of the literature review is determining the parameters within which DVSA service standards will be considered. The '**Movement Towards Violence as a Health Issue**' presents a unique perspective (www.violenceepidemic.org, 2018). Formed in 2015 by over 500 individuals representing over 150 organizations addressing violence in the U.S., the Movement seeks to develop and advocate for state-level investments in **health-based violence prevention**. Led by former Surgeon General Dr. David Satcher, the primary message is that "violence is a health issue and needs to be treated as one[4]." With an emphasis on prevention, the Movement aims to transform the existing paradigm from violence as moral corruption or in response to economic and environmental factors, to violence as a health epidemic that cannot be incarcerated away. Their research has linked violence to death, heart disease and cancer. Many of the factors that increase the likelihood of violence mirror the social determinants of health, including higher risk of mental illness, childhood malnutrition, and propagation of violence throughout generations. Within this perspective DVSA may be a more palatable subject for discussion in the Samoan culture, as 'soifua maloloina' or good health is a viewed as a top priority. It could also make DVSA more clearly relevant to primary care practitioners at LBJ Hospital and Department of Health.

The European Union and United Nations promote a **gendered understanding of violence** denoting violence as both cause and consequence of the inequality between women and men and the foundation for recognition of **violence against women as a human rights issue**[5]. This perspective views violence as an unequal power relationship between the genders, perpetuated by the social, political and economic structures that govern our world, and of which men are inherently the majority leadership. The European minimum standards modified this 'culture of belief', supporting in its stead a 'culture of empowerment'[5]. Rather than band-aiding the outcomes of violence i.e. using criminal prosecution, victim services should empower service users, an approach which respects the victim's dignity, integrity, and enables the victim to make informed decisions about his/her future.

Much of the literature from the U.S. endorse a **victim-centered approach to crisis management** which focuses on the immediate needs of the victim of DVSA in relation to the criminal and clinical aspects of the incident[9]. This perspective emphasizes 'crisis intervention' as a response to recent assault. Standards

based on this approach, while appropriately focused on aiding the victim, address the interactions between the victim and the social, justice, and clinical services needed at initial contact rather than a continuum of care along the journey to recovery[19, 20, 23]. **Civil rights and justice** guide this value system. As an example, the St. Paul (Minnesota) Domestic Abuse Intervention Project, in collaboration with Praxis International, developed a 'Blueprint for Safety' and corresponding 'Guide to Becoming a Blueprint Community'. The six foundational principles of a 'Blueprint Community' focus on the 'context and severity of abuse into each intervention' and 'recognize that domestic violence is a patterned crime' for which 'messages of accountability to offenders' and 'consequences' for 'continued abuse' are an integral part of intervention goals[22].

The second aim of the literature review is to assess **how standards are developed and by whom**. While there are no U.S. national standards for service provision to victims of DVSA, most states have adopted legislation reflecting a minimal set of guidelines for service providers in their communities. The written standards vary from detailed policies and procedures such as those developed by the Arizona Coalition Against Domestic Violence in partnership with the AZ state government in 2000, to the protocols and 'authoritative statements' established by the Attorney General's Office of New Jersey in 1998[19,25].

The Office on Violence Against Women completed a Sexual Assault Demonstration Project (2017) which lists recommendations for minimum standards based on their four-year process of assessing, planning and implementing new and enhanced services in six sites[20]. The report findings include a 'lack of foundational understandings of sexual assault trauma and advocacy' leading to various recommendations for core sexual assault services. One of the six sites developed innovative **'Core Competencies' for staff**, categorized by fundamental management skills, field-specific management skills, and external roles such as public speaking. These types of developments evolve into standards that others in the field build upon and adapt to the needs of victims in their unique communities. One of the primary recommendations from this national project was the technical assistance sharing between state coalitions and other non-profits.

The scope of the literature review includes international DVSA service protocols and standards. Outside of the European Union there are few resources describing standards in specific European countries. There is little online data from the Asian region. Due in part to the high level of funding from the World Health Organization, there are several DVSA reports from African countries and the South Pacific region. Of particular interest is the 'Service Charter for Victims of Crime in South Africa'[26]. The minimum standards set forth in the Service Charter are provided as a tool for victims to ensure they receive appropriate assistance and services. It is also a guide for victims when encountering the social and criminal justice systems, iterating the level of service they should demand, and their rights as victims. The standards also provide metrics to which all services and providers may be evaluated. The narrative is founded upon restorative justice principles and aligns with the UN's Declaration of the Basic Principles of Justice for Victims of Crime and Abuse of Power.

The National Standards of Practice for Services Against Sexual Violence from Australia (Exhibit A), reviewed in 2012 and revised in 2015, highlights '**Cultural Competency**' as a minimal standard for organizations and providers[9]. Each of the standards includes a cultural component. In the standards for 'access' the use of interpreters is a focal point; for 'counseling' the term 'culturally infused' service is

emphasized, and in each of the ten areas for which standards are in place, practitioners are required to 'modify or tailor services to resonate with the perspective of each client so that each client may be served effectively'.

According to the literature, the United Nations, European Union and World Health Organization are influential in the development of DVSA service provision standards throughout the world. Standards are grounded in ethical principles and promulgated through policy documentation. Standards may be used to evaluate services, as requirements for funding, or in terms of ethical codes the standards may be required for membership. However, similar to the U.S., there are no formalized international standards for DVSA[5].

Defining a Minimum Standard for DVSA Services

With the preliminary data from the Gap Analysis, the Alliance is prepared to develop recommendations for minimum standards in American Samoa for 'Core Services' (Figure A) as they become established in the territory. Minimum standards can be considered the lowest possible common denominator that all service providers should aim to achieve. Standards also provide benchmarks or metrics with which to measure and compare the extent of services provided, by whom, how they are delivered, and the principles and practices supporting service provision[5].

These services could be coordinated by either of two organizing mechanisms: the Sexual Assault Response Team (SART) or the Rape Crisis Center (RCC) which is essentially a comprehensive service site (also known as a Sexual Assault Center).

FIGURE A: Minimal Levels of Provision for Core Services[5]

Service/Product	Basic provision	Gold standard
Help/Hotline	One national line covering all violence against women staffed 24 hours by trained responders to provide caller with direct support, solutions, and possible instructions if needed.	One national line for domestic violence and one national line for sexual assault/rape staffed 'live' 24 hours by trained responders to provide caller with direct support including direct link to emergency response services; monitoring extent of missed calls
Shelter	One per 10,000 of population, with capacity to house women and children, and provide support from min. one Specialist in Violence; provide basic emergency necessities and transportation. Services should be provided by female staff. Crisis support and safety planning should be provided for each user – preferably a written needs assessment within 3 days of intake.	Range of services: accommodation for women with special needs including migrants, disabled, behavioral health issues, drug abuse; transportation. Written policies and procedures in place to manage the shelter as well as Case Management completed through release. Minimum one qualified childcare worker on staff. A follow-up plan post-release is highly effective – suggest 30-day and 6-month safety checks.
Rape Crisis Center	One per 200,000 women; min. one Specialist in sexual violence. Services should include anonymous phone helpline, individual counseling, accompaniment to other services,	Integration with assigned health provider, law enforcement and forensic services. Should also include advocacy, protocols for suicide and crises, and third-party callers,

	advocacy. Min. 30 hours in staff training in all areas of DVSA.	legal advice, and financial assistance hospital accompaniment
Sexual Assault Center	One per 400,000 women; min. one Specialist in sexual violence. Service minimums should be same as Rape Crisis Center	Integration with assigned health provider, law enforcement and forensic services. Provide equitable access to quality medical care; established age specific protocols.
Professional Counseling Services	One per 50,000 women; min. one Specialist in Violence; can include Shelters, Rape Crises and Sexual Assault Centers	Counseling provider should be integrated with other DVSA service providers; direct contact with emergency services when needed; Counselors should have min. 30 hours training in all areas of DVSA and able to develop individual action plans for clients
Advice/Advocacy Project	One per 50,000 women	Sustainable relationships w/DVSA service providers, media and legislative entities; Advocates have 30 hours training in all areas of DVSA with Certification where available
Education/Outreach	target at-risk groups, especially minorities, and staff trained in cultural competence	Co-location with other service providers; translators and bilingual materials available
Perpetrator Programs	i.e. Batterer's rehab - facilitated by professionals and not provided as an alternative to prosecution, conviction or sentence. Safety and well-being of women and children supersedes benefit to perpetrator, and should not include relationship mediation or counseling or substance abuse treatment.	Protocols should be in place for cooperation with local substance abuse treatment programs. Programs should have active links to child protection and social service agencies. Staff complete 30 hours training.

The Rape Crisis Center or Sexual Assault Center, and Perpetrator Programs are the only services not currently offered in the territory. All other services are available by an uncoordinated limited network of providers which includes the Alliance and other NGOs. The minimum standards will be used to guide the development of a formal coordinated response to DVSA crimes for the benefit of DVSA victims. The following standards and underlying principles clearly define **how services should be provided**.

FIGURE B: Minimal Standards of Provision for Core Services

Service/Product	Minimal Standards[5]	Foundational Principles
Help/Hotline Shelter Rape Crisis Center Sexual Assault Center Professional Counseling Services Advice/Advocacy	• Promote the well-being, physical safety and economic security of victims and enable women to overcome the consequences of violence to rebuild their lives • Work from understandings of violence against women which neither excuse or justify men's violence or blames victims • Co-operate and co-ordinate with all other relevant services	• Confidentiality • Safety, security and respect for service users and staff within a culture of belief that sides with the victim • Accessibility – ensuring all women can access support • Availability – crisis, medium and long term provision with 24/7 access where safety is immediately compromised • Free of charge

Education/Outreach Perpetrator Programs	• Empower and enable women to take control of their lives within a 'culture of empowerment' which begins with the language we use to name and make sense of the violence • Ensure that victims have access to appropriate services and that a range of support options are available that account for the particular access needs of women facing multiple discrimination. • Ensure that service providers are skilled, gender-sensitive, have ongoing training and conduct their work in accordance with clear guidelines, protocols and ethics codes and where possible, provide female staff • Monitor and evaluate service provision, seeking participation of service users	• Services should work within a gender analysis of violence against women • Support and interventions should employ the principles of empowerment and self determination • Specialist provision should be provided by women for women • The expertise of specialists in violence against women sector should be recognized and developed through training • Holistic services – addressing all forms of violence • Inter-agency coordination and intervention chains and referral processes and protocols • Maintain the confidentiality and privacy of the victim

Organizing the Standards

The 'Standard' is the minimum benchmark for the conduct, performance, knowledge requirements, service provision and quality of services provided to DVSA victims[19]. Each standard should be based on underlying principles which validate its requisite for performance.

Each standard should be comprised of outcomes and measures: what will result from use of the standard and how this result be measured. Outcomes can also pertain to how standards will be applied to service provision.

Measurement criteria set the objective yardstick with which outcomes are evaluated. They may also establish a baseline for action plans to develop standards, improve services, and establish services. Methods, training and service standards should include relevant benchmarks that guide providers towards identifying and establishing best practices.

For example, the following standard for referral is taken from the Australian National Standards for DVSA (2012) – see Exhibit A for standard provision:

> Rationale/Underlying Principles:
> Substantive equality, availability and access, advocacy and increasing referrals
>
> Standard for Referral Resources:
> Referrals include a total transfer of the client to another agency, or to additional services for the purpose of meeting complex needs, such as psychiatric/mental health services.

Minimum Practice:
There is evidence to show that the organization maintains up to date information about relevant services to enable high quality and appropriate personalized referrals; builds relationships with relevant key stakeholders as part of a systemic and individual advocacy, and has a wide range of relevant information readily accessible to clients.

Metrics: (example)
The organization service database is comprised of 100 relevant services for referrals; providers establish and maintain at least 15-member organization MOUs; referral database is updated monthly.

The trauma-informed approach

In addition to the 'what' and 'how', the standards should also advocate from a particular perspective or approach (See Literature Review, p. 4). The evaluation of the Sexual Assault Demonstration Initiative documented a widespread change in services across sites: a shift towards placing primary importance on active listening and trauma informed approaches. Evaluators noted that 'while tangible needs are important', i.e. shelter, transportation, clothing and referrals, when these needs 'define the nature and mode of service delivery to the exclusion of other needs, emotional support is sacrificed, and other survivors are left unsupported[20].' The experience of SA victims may differ from DV victims in that they may not need tangible resources, but rather emotional support as a service. By focusing on trauma, providers practice **victim-defined advocacy**.

Understanding trauma and using trauma-informed techniques when working with DVSA victims is viewed as a standard for service provision. The approach guides screening, intake, and service protocols. A trauma-informed service incorporates a basic understanding of the role of violence and how it affects lives[9]. It also integrates the victim's history and context of their experience into service provision. This context may include the victim's community, religion, social-economic factors – the context in which the victim experiences the trauma. Resilience, the ability to survive the trauma and successfully cope with the after effects, is at the heart of the trauma-informed approach.

Trauma-informed services comprise six basic elements[9]: safety, trustworthiness, choice, collaboration, empowerment and cultural relevance. The literature emphasizes the need for a 'trauma informed organizational culture' to support the provision of services. Both policy and practice must foster growth, wellness, and self-care for staff as well as the clients they serve.

In terms of cultural relevance and adaptation it is important to remember that the Samoan culture places value on the collective experience. Trauma in the psychological sense is not defined in the Samoan language as extensively and distinctly as in English. This is one example of the critical importance of core competencies of service providers.

Core competencies for Staff

Professional development is an important part of effective organizational management. Preventing burnout, managing organizational trauma, trauma informed supervision, maintaining confidentiality are unique components of DVSA staffing competencies. Each set of standards reviewed in this project included requirements for staff development, training, and self-care. The minimum number of hours of professional training in DVSA competencies is 30 annually but is documented as high as 40. These are in

addition to the minimum educational requirements for staff positions. The literature also supports the following providers' perspectives which support effective approaches to DVSA cases[21]:

Victim-centered – recognizing and prioritizing the needs and rights of victims whenever possible, which includes victim self-agency.

Offender-focused – conveying to victims and offenders that DVSA is a crime that will be pursued through the justice system. Offender accountability is the responsibility of the justice department not the victim.

Commitment to 'believing' – from the outset ensuring the victim that their experience is valid, and that their safety and security is of primary importance to the service provider

Recommendations

The most critical need in the local provision of DVSA services is **a coordinated response**. Without effective communication between providers, and engagement of the community, victims will continue to suffer from revictimization, lack of timely access to services, and loss to follow up. A committed effort to build networks that will reduce isolation, share resources, and act in solidarity is needed. A **leader is also needed to spearhead the effort** – most likely an NGO whose operations and governance are not affected by political turnover.

Secondly, this group will need to determine its immediate focus. An assessment of culturally specific programs will provide a baseline from which to build a **strong referral system**. Categories may include:

- Types of gender-based violence addressed
- Services/interventions offered
- Language of these services
- Ethnic and demographic groups served
- Systems that programs work with including partners, funders, technical assistance, volunteers
- Community engagement and prevention activities
- Research, policy advocacy and training activities

Policy is the most sustainable type of change with the greatest impact. **Legislation and organizational policy** provide a foundation upon which a coordinated network of responders can then develop an effective response to DVSA. Examples of policy change include assessment of DVSA responses in the clinical and legal fields, developing approved guidelines for service which incorporate trauma-informed values and advocacy, prioritizing and improving data collection about DVSA in territorial surveillance systems.

Advocacy to incorporate **routine DVSA screening** in all areas of public service provision is critical. The literature reveals that institutional support, effective screening protocols, consistent on-going training, and immediate access or referral to support services do improve DVSA service delivery[12, 17].

Finally, promoting **health care partnerships** with DVSA programs will improve the coordination of response to victims. By changing the paradigm from DVSA as a criminal/justice issue to DVSA as a health epidemic DVSA becomes relevant to all human beings whether they are victims or not, and in spite of attitudes of denial or blame[17,27]. Local healthcare providers must be engaged partners in the provision of DVSA services.

EXHIBIT A: Australia's Natl. Standards of Practice for Services Against Sexual Violence (2015)[14]

Standard	Minimum Practice	Best Practice
Cultural Competency	Providers must be willing to address issues of difference arising out of race and culture; recognize that addressing diversity is a continuous learning effort; modify services to resonate w/the perspective of each client so that each is served effectively	Makes a clear statement that recognizes and values diversity; commits resources to improve cultural competency of employees; engages in networking with diverse and minority cultural groups; has strategies to improve access to its services by diverse groups
Increasing Access	Organization can articulate its capacity for service delivery; is committed to improving access to services; is actively engaged in trying to reduce access barriers; can measure the effectiveness of any access strategy implemented	Organization commits resources to systems and client advocacy; consults with marginalized groups to identify needs and barriers to services
24-hour Services	Organization has systems in place to facilitate 24-hour on call access to SA counselors when recent SA has occurred; has systems ins place to redirect after hours calls	Organization provides 24-hour on call services with sufficient protocols to ensure service quality, client confidentiality, and staff safety
Outreach	All aspects of outreach are evaluated; outreach is planned with risk assessment and safety procedures in place	The organization's work health safety policies have provisions covering outreach service provision
Referral	Resources are updated and enable high quality referrals; organizations build relationship as part of systemic and individual advocacy; have a wide range of relevant info accessible to victims; consent should be verbal/written and recorded; level of client info sharing should be approved by client in writing	Personalized referrals are prioritized over cold referrals; client have option recontact Referer; protocols exist to enable follow up contact
Client Advocacy	Organization has knowledge of advocacy services that may benefit its client; informs clients of their rights to, and availability of, advocacy; ensures written client consent as a pre-requisite for advocacy work	Should have protocols to support providers; provide opportunity for professional development of advocacy; be able to quantify and describe its advocacy work
Client Engagement	Organization recognizes that a victim may be in crisis at any point in their journey to recovery, at recurring points, when triggered by events; operates using client-centered model of care; every employee is trained in SA	Intake protocols are detailed enough to match client with appropriate service and provider; data collection systems are in place; 'acute care' is the general level of responsiveness for every client
Consent	Informed consent forms part of establishing therapeutic goals and is ongoing throughout the process; receiving written consent is a condition of receiving services	Provider reads any consent related documents in appropriate language of client and explains in detail

EXHIBIT B: Council of Europe Proposals for Min. Standards for DVSA Services (2008)[5]

CORE MINIMUM STANDARDS	
Basic Standards - Applicable To All Services	**Aspirational Standards**
RESPECT & DIGNITY	
Service user has a right to be treated with respect and dignity at all times.	Face-to-Face contact should be within a safe, clean, and comfortable environment.
Confidentiality must be guaranteed. Any written or spoken communication or other information containing anything that can identify the service user should only be passed on to others with the service user's informed consent. The only exceptions are: • To protect the service user, when there is reason to believe that her life, health or freedom is at risk. • To protect the safety of others, when there is reason to believe that they may be at risk. Confidentiality policies should be explained clearly to the service user before any services are provided.	All records should be kept locked and secure, only accessible by authorised persons. Services should have a policy for obtaining written consent to the release of confidential information, and staff must be trained on this.
All services should begin from the twin principles of a culture of belief with respect to victims and accountability of perpetrators.	
SAFETY & SECURITY	
Safety and Security should be the paramount considerations. This refers to the safety of the service user, any children and vulnerable persons related to their case, and staff. Safety here is not just immediate physical protection, but psycho-social safety, including social inclusion.	
Crisis services should be available and accessible round the clock i.e. 24 hours a day, 365 days a year.	Services should be equitably distributed across geographic areas and population densities.
Services should be holistic and user-led. The Service provider should be competent to: • Provide what the service user needs or is requesting; • Where this is not possible, refer the service user to relevant services.	
ACCESSIBILITY	
Services should be available to all women. This may require outreach, adaptation of service provision to service user's needs, and the development of specialist services (i.e. for migrant, ethnic minority, or disabled women).	• Interpreters should be trained to deal with violence and sign confidentiality agreements • Service Providers should ensure that their buildings and facilities are accessible for women with physical, auditory and learning disabilities. • Outreach should be undertaken with underserved/hidden (migrants, women with disabilities, lesbians, women in the sex industry) communities.
Services should have anti-discrimination and equal opportunity policies with respect to staff and service users.	• Services should be moving towards widening access • Links with services that provide specialist services to minority communities – building joint training and satellite services
Services should be provided free of charge.	Where this is not possible, invoices should be subject to the clear condition that service provision would not be withheld on the grounds of the service user's inability to pay.
CHILDREN	
Service providers should be mindful of the needs of children of service users and their specific responsibilities with respect to girls and young women.	• Attached specialist provision for children/girls/young women. • Services should have a child protection policy and staff should be trained on it.
Children should not be used as regular translators for their mothers.	

STAFF	
Staff should be appropriately qualified and trained: (a) Minimum initial training and a minimum ongoing training should be part of employment contracts; (b) Initial training should include understanding of the gendered dynamics of violence, awareness of the different forms of violence against women, anti-discrimination and diversity, legal and welfare rights; (c) This standard also applies to all relevant professionals in state and non-state agencies. Here, specialist NGOs should be used as trainers and paid appropriately.	Service providers should ensure they and their staff are up to date on current research and recognised good practice. Staff should receive regular supervision and support.
Women's NGOs should be staffed by women, and other agencies should ensure availability of sufficient professional female staff, including interpreters, medical staff, and police officers.	Staff recruitment should reflect diversity
EMPOWERMENT	
Services should be managed democratically. Both staff and service users should have opportunities to participate; ensuring that male dominance is not replaced by institutional dominance in the service user's decision-making processes.	
Service users should be informed of their rights i.e. what services they are entitled to receive, what their legal and human rights are.	
Service user's right to receive information and support should not be conditional upon making an official complaint, agreement to attend any kind of programme/group/service. Service users should have sufficient time to reflect on information in order to make informed decisions.	
All information, advice and counselling should be based on empowerment and victim rights models: (a) Informed consent should be obtained before any action or procedure is undertaken (b) All service providers should prioritise the best interests of the service user (c) It is the service users decision whether to make an official report to the police	
Service users should have the right to access their own records, including making comments and request that they be amended or updated.	

PROVISION	
Services provided by NGOs should be autonomous, non-profit making, sustainable and capable of providing long-term support.	
National and local governments should have funding streams for violence against women services.	
All services should be based in a gendered understanding of violence as a cause and consequence of women's inequality.	Service providers should engage in community awareness raising to change the conditions which make violence acceptable
Services should develop through attention to service user needs; actively seeking the views of service users and taking them into account should be a core part of regular monitoring procedures.	Services should; • have clear complaints procedures • seek funding to enable participation • seek external evaluation which prioritises the perspectives of service users
Services should develop guidelines for multi-agency cooperation.	Protocols and memorandums of understanding with key external agencies
Data should be collected and maintained in a systematic way on service user demographics and nature of offences, in ways that do not violate the service user's rights to confidentiality.	Services should produce annual or bi-annual analysis of their users and their experiences.

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