SAFENET GUIDEBOOK 2017

THE SAFENET STANDARD OPERATING PROCEDURES FOR REFERRAL AND COORDINATION OF SEXUAL AND GENDER BASED VIOLENCE SERVICES

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- Department of Women
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- Family Violence Unit
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Preamble

SAFENET is a network of government and non-government organizations to strengthen referral and coordination of sexual and gender based violence (SGBV) services in the Solomon Islands. It aims to streamline the assistance being provided to survivors and help them access more timely and necessary services.

It has four inter-connected components: SGBV direct services and support; referral to other service providers through an agreed and coordinated formal referral process; prevention and advocacy programs; and, governance and accountability framework.

With SAFENET the four core sectors of front line service, and supporting partners, have a strong coordinating mechanism with clear standards and processes to better coordinate and improve services. SAFENET in Solomon Islands is supported by the Ministry of Health and Medical Services (MHMS), Royal Solomon Island Police Force (RSIPF), Public Solicitor's Office (PSO), Family Support Centre (FSC), Christian Care Centre (CCC) and the Ministry of Women, Youth, Children and Family Affairs (MWYCFA).

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ACRONYMS

A&E	Accident and Emergency
ARCC	Advisory Reporting Coordination Committee
CCC	Christian Care Centre
CISP	Confidentiality and Information Sharing Protocol
CO	Commissioners Orders
CO/SAI/FV	Commissioners Orders on Sexual Assault Investigations and Family Violence
CWA	Child Welfare Act
DV	Domestic Violence
EVAWG	Elimination of Violence Against Women and Girls
FPA	Family Protection Act
FPAC	Family Protection Advisory Council
FPO	Final Protection Order
FSC	Family Support Centre
FV	Family Violence
GBV	Gender Based Violence
GEWD	Gender Equality and Women's Development
HCCN	Honiara City Council Nursing
HPD	Health Promotion Division
IMHS	Integrated Mental Health Services
IPO	Interim Protection Order
MHMS	Ministry of Health and Medical Services
MoH	Ministry of Health
MOU	Memorandum of Understanding
MS	Minimum Standards
MWYCFA	Ministry of Women, Youth, Children and Family Affairs
NAAC	National Advisory and Action Committee on Children
NCPG	National Clinical Practice Guidelines
NETF	National EVAWG Task Force
NRH	National Referral Hospital
NST	National Stakeholders Taskforce
PSO	Public Solicitor's Office
RMNCAH	Reproductive, Maternal, Nutrition, Child, Adolescent Health
RSIPF	Royal Solomon Islands Police Force
SCA	Survivor Centered Approach
SGBV	Sexual and Gender Based Violence
SIG	Solomon Island Government
SOP	Standard Operating Procedures
SRF	SAFENET referral form
STI	Sexually Transmitted Infections
SWD	Social Welfare Division

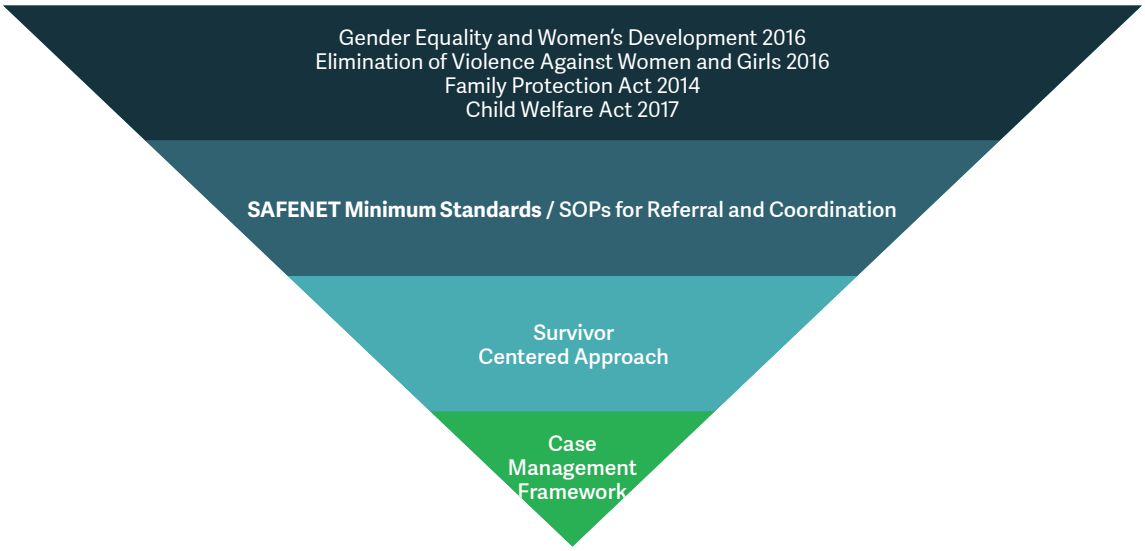
SECTION I: INTRODUCTION

1.1 SAFENET STANDARD OPERATING PROCEDURES (SOPS)

The Memorandum of Understanding (MOU) for the referral SAFENET provides written details of the agreement between six (6) key parties offering sexual and gender based violence (SGBV) services: the Ministry of Health and Medical Services (MHMS), Royal Solomon Island Police Force (RSIPF), Public Solicitor's Office (PSO), Family Support Centre (FSC), Christian Care Centre (CCC) and the Ministry of Women, Youth, Children and Family Affairs (MWYCFA). It specifies the different roles and responsibilities for each member, the use of the SAFENET name and logo, publicity and monitoring and evaluation. The SAFENET Standard Operating Procedures (SOPs) are intended to compliment the MOU and outline procedures and processes to standardize SAFENETs approach to referral and coordination of SGBV services across the multiple sectors.

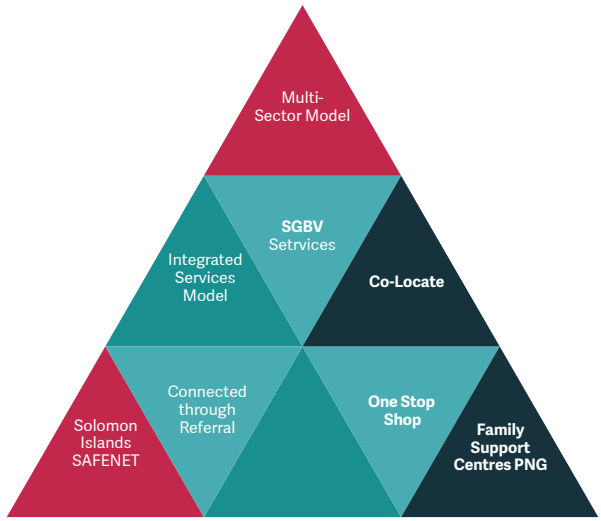
The context for the SOPs is a mix of policies and legislation (see Graphic 1) including the Solomon Islands National Gender Equality and Women's Development Policy (GEWD) (2016-2020) and the National subsidiary policy on Eliminating Violence Against Women and Girls (EVAWG)(2016-202); the Family Protection Act (FPA) (2014) and the Child Welfare Act (CWA) (2017). The SAFENET SOPs align with new SOPs in the Health and Police sectors: namely the National Clinical Practice Guidelines (NCPG) (2016) for the Ministry of Health and Medical Services and the Commissioners Orders for Sexual Assault Investigations (Victim Protection) (CO/2016/NO/002) and Family Violence (FV) (CO/2016/N0/003), as well as the 2013 Solomon Island Police Force SOPs for Investigations.

Graphic 1: SAFENET Policy Context



The Referral SAFENET SOPs and Minimum Standards align with the multi-sector, integrated services model of SGBV response and prevention in the Solomon Islands (SI) (see Graphic 2). In the integrated services model SGBV services are integrated into existing health, psycho-social, police and legal services and connected through referrals to the appropriate support. The approach includes both primary and secondary prevention, with a greater focus on secondary. Primary prevention efforts, undertaken individually and collectively within SAFENET, enhance the protective factors that prevent SGBV. The multi-sector 'one-stop shop' approach, within which SGBV services are co-located in one building or compound, has not progressed beyond discussion.

Graphic 2: Multi-Sector Integrated Service Model Solomon Islands



The SAFENET SOPs draw on research in survivor centered and case management approaches used to assist victim/survivors to negotiate service networks. They build on consultations with SAFENET service providers (in July 2014 and February 2016) and survivors about the experience and practices of SAFENET staff in achieving safe outcomes. The agreed Minimum Standards (MS) stem from the SAFENET capacity diagnostics, which clarified a common language and outlined specific details of the SAFENET survivor centered approach (SCA).

These SAFENET SOPs aim to standardize the approach to SGBV in direct services, referral support, coordination and prevention interventions amongst the member organizations. They describe, first and foremost, the SAFENET approach and the roles and responsibilities of each SAFENET member organization. The SOPs recognize that the experience and trauma of survivors is impacted by attitudes and practices of service providers, who can either provide a safe, supportive and sensitive response, or do more harm by encroaching upon the safety, dignity and mental well-being of those they serve.

Sector SOPs for the MHMS and the RSIPF were approved in 2016 by the relevant Ministry authorities and are integrated into the SAFENET SOPs. Individual agency SOPs for PSO, FSC and CCC have been revised and approved as official documents of SAFENET by CARECOM on May 9, 2017. They are included in Section 6 of the SOPs.

SECTION II: SAFENET COMPONENTS

2.1 SAFENET COMPONENTS

SAFENET is a network of government and non-government organizations made up of 4 inter-connected components to strengthen referral and coordination of SGBV services in the Solomon Islands: SGBV direct services and support; referral to other service providers through an agreed and coordinated formal referral process; prevention and advocacy programs; and, governance and accountability framework.

2.2 DIRECT SERVICES AND SUPPORT

The SAFENET offers 7 types of direct services and support for victim/survivors of SGBV: medical treatment and first aid services, mental health services, shelter, welfare child protection, counselling, legal and para-legal support and police /security. Risk assessments and safety planning, case management and data collection cut across all SAFENET services. A national 24 Hour Hotline is staffed with volunteers in Honiara (see Graphic 3).

2.3 REFERRAL AND COORDINATION

SAFENET coordinates SGBV services to enable referrals between its members. To facilitate a multi-sectoral government and non-government holistic response a number of coordinating mechanisms are in place:

- SAFENET MOU between government and non-government partners (signed in June 2017);
- CARECOM - the governing body for SAFENET with 11 members;
- the SAFENET secretariat housed within a CARECOM member organization currently the SWD under the MoH;
- SAFENET coordinator;

- Minimum Standards for referral and coordination of SAFENET services, aligned with national legislation and SOPs in the health, Justice and police sectors (approved by CARECOM on May 9, 2017);
- An agreed guiding principle outlining a survivor centered approach;
- A glossary of terms using definitions from policy and legal documents to reinforce a common understanding of SGBV for response, prevention, advocacy and training (Annex 1);
- The SAFENET Referral Form to capture consistent information about SGBV incidents and help coordinate the SAFENET response;
- CARECOM bi-annual meetings to feed into reporting to the National EVAWG task force, the GEWD National Stakeholders Taskforce (NTS) and the Advisory Reporting Coordination Committee (ARCC);
- Regular SAFENET meetings to enable discussion of response issues, case conferences (see Section 4.5 of SOPs), prevention and collective actions (see Graphic 4).

While the coordination mechanisms aim to strengthen the links between SAFENET service providers, referral utilizes the links created to access different and more specialized services in the system.

Referral involves making contact with other SAFENET focal points such as police and health practitioners to ensure support for each case, to prioritize response and move beyond systemic barriers in the delivery of SGBV services. Referral amongst SAFENET member's assists' survivors/victims to access SGBV services they might otherwise be unable to access (see Minimum Standard #1).

2.4 PREVENTION AND ADVOCACY

The endemic nature of SGBV/FV highlights the critical need for primary prevention strategies and interventions. All SAFENET members have a responsibility to take action to address the causes and contributing factors of SGBV. SAFENET members are implementing a range of primary and secondary prevention strategies targeting women, men, boys and girls, young adults of both sexes, religious and traditional leaders, and service providers and policy makers (see Table 1).

Graphic 3: SAFENET SGBV Services

Graphic 4: SAFENET Coordinating Mechanisms

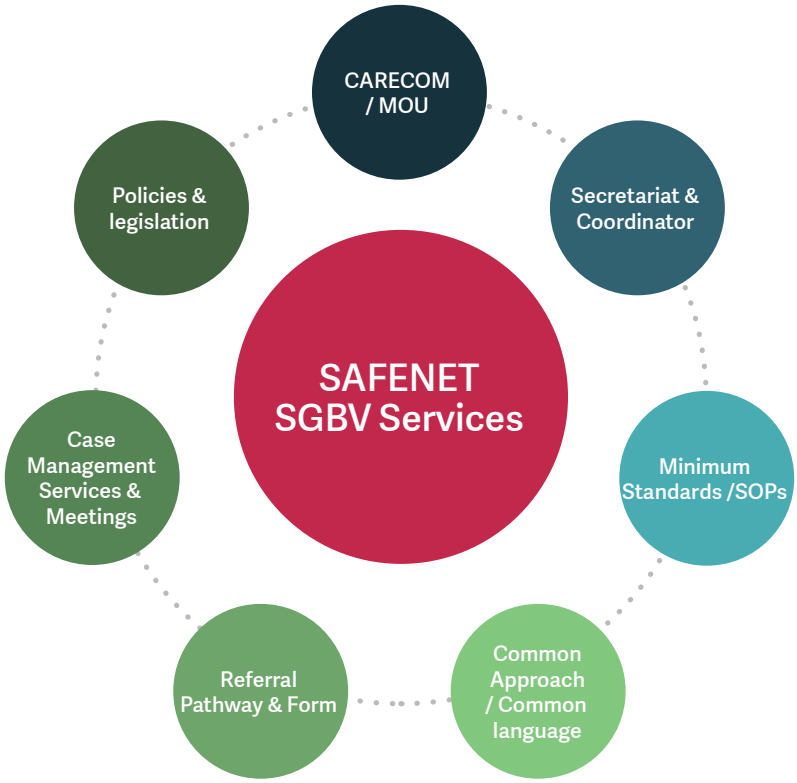


Table 1: SAFENET SGBV PREVENTION STRATEGIES

SAFENET members prevention strategies include actions that focus on a range of issues:
• Influencing changes in socio-cultural norms through awareness raising and behaviour change strategies, particularly targeting youth and men;
• Facilitating empowerment of women and girls;
• Strengthening family and community structures and support systems;
• Designing safe, effective, accessible, integration, and survivor oriented government and non-government SGBV services and facilities;
• Integrating gender based violence response and prevention programs into
• Working with formal legal and traditional Kastom systems to ensure that their
• Advocating for gender and child sensitive polices and laws aligned with international human rights standards; and
• Generating a SGBV evidence base and monitoring it to identify achievements and problem areas.

2.5 SAFENET GOVERNANCE AND ACCOUNTABILITY

The *Technical Advisory Monitoring Committee (CARECOM)* is made up of the Directors of:

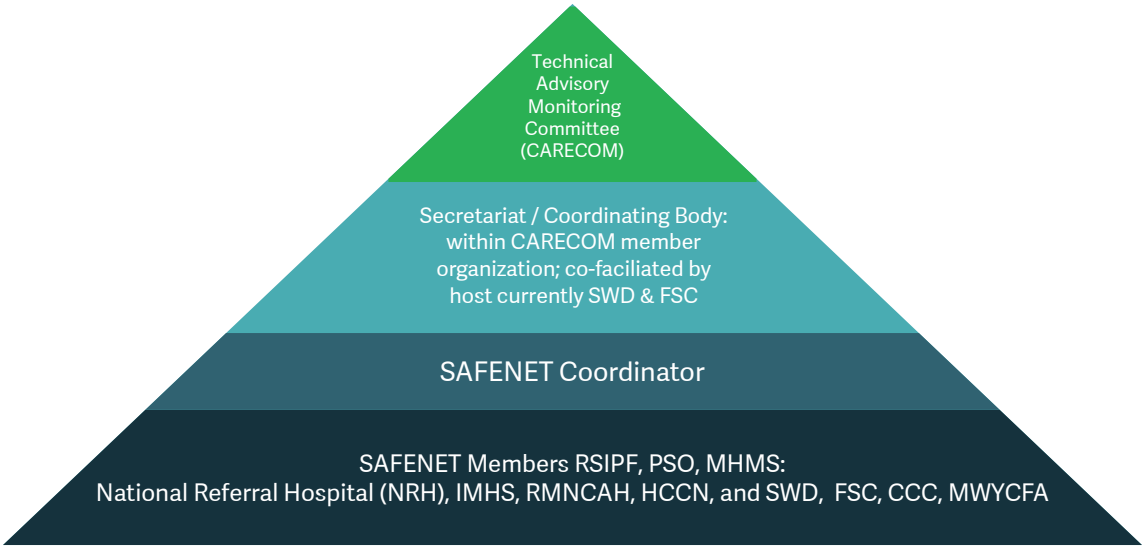
- Accidents and Emergency (A&E)
- SWD MoH;
- Integrated Mental Health Services (IMHS) MoH;
- Honiara City Council Nursing (HCCN) MoH;
- Reproductive, Maternal, Nutrition, Child, Adolescent Health (RMNCAH) MoH;
- Women's Division MWYCFA;
- Children's Division MWYCFA;
- National Community Policing and Family Violence Unit;
- CCC Coordinator;
- FSC Coordinator;
- Public Solicitor;
- and invitees of the committee as needed.

The role of CARECOM is to

- Review and approve an annual plan and budget for SAFENET;
- Review and approve SAFENET proposals for fundraising;
- Review and approve SAFENET annual reports for the Elimination of Violence Against Women and Girls (EVAWG) and Gender Equality and Women's Development (GEWD) reporting process in line with policy requirements (see Annex)
- Approve SAFENET SOPs, protocols and tools for referral and coordination;
- Provide advise to SAFENET members on SGBV/FV multi-sector referral and coordination;
- Review and approve recommendations for SAFENET membership from the vetting process implemented by the SAFENET secretariat;
- Hold SAFENET members accountable to implement coordinated SGBV/FV services according to SAFENET Minimum Standards;
- Receive and investigate complaints within the multi-sectoral SAFENET referral system;
- Report complaints and investigation findings to relevant authorities of member organizations/ agencies and to FPAC as required in Part 5 Section 49 of the FPA re: implementation of service;
- Consult and communicate with line ministries and/or organizations regarding breaches to Mini mum Standards of Practice and internal disciplinary procedures;
- Represent SAFENET and multi-sector referral and coordination in the national EVAWG / GEWD process; and,
- Advocate the services of CARECOM and SAFENET within sector and line ministry to encourage consultation with CARECOM regarding any new SGBV / FV services and to ensure the Minimum Standards of practice are advocated and followed.

The Secretariat of the Referral SAFENET will be housed by one of the CARECOM members. Running this is a joint responsibility between the host, currently SWD, and the FSC each of which will provide joint administrative support. It will be staffed with at least one full time paid coordinator, supervised and supported by the host Ministry/division/organization.

Graphic 5: SAFENET Governance Structure



SECTION III: SAFENET GUIDING PRINCIPLES

SURVIVOR CENTERED REFERRAL SERVICES:

The Referral SAFENET offers survivor centered services. This means the survivor is placed at the center of the helping and referral process (see Graphic 6). Survivor-centered services create a supportive environment in which the survivor's rights are respected and she is treated with dignity and respect. All actions revolve around her needs, her rights and her decisions. The survivor leads decision making through the choices she makes for support. Her wishes are respected.

Graphic 6: Survivor Centered Approach

To ensure the survivor has a clear voice throughout the referral process service providers must

- inform her of her rights and responsibilities,
- assist her to identify and express her needs,
- help her to choose a course of action, and,
- support her to take decisions about the course of action.

Table 2: Survivor Centered Services

Survivor-Centered Services
Survivor is the expert.
Case Manager comes to the survivor and accompanies her to get help.
Survivor can obtain services without retelling the story
Survivor decides what information will be shared.
Information shared only on a "need-to-know" basis and with survivor's permission.
Survivor decides what steps to take after given information about rights and options.
Survivor given good help no matter her history or number of times she has asked for help.
All services have a SGBV safety-first policy
Records for SGBV are kept separate to protect the survivor's confidentiality and safety.

Through the process service providers ensure the victim/survivor can make decisions freely. They reinforce her capacity to make decisions and promote her recovery. Services should always aim at supporting survivors to choose the course of action to deal with the violence instead of feeling powerless. They keep the survivor in control of all actions undertaken and accept when she doesn´t want to separate from a violent partner. This helps survivors to begin to re-gain control of their lives and to promote their right to autonomy and self-determination[1]. SGBV is an assault on the dignity and rights of a person and all those who come into contact with her have a role to play in restoring her dignity and her rights to self-determination i.e. her right to choose whether or not to access legal, police or shelter services (see Table 3).

A SCA uses empowerment counselling. Empowerment counselling is NOT therapy. Rather it is crisis and short-term support with a goal of restoration of the victim's dignity, power, and control over her own life. It builds upon the survivors own strengths and resources.

The term survivor encompasses both survivors and victims. It is the language of hope, used in appreciation of the woman or girl, man or boy, having survived the experience of violence and to encourage them to carry on. The use of the term survivor/victim in parts of the SOP recognizes that those traumatized by violence may need time and support to heal, to gain their confidence and self-esteem back and to take control of their lives. The dual term recognizes that some agencies are responding at a point in a survivors' life when they are still victimized by violence and its many consequences.

1 Sources: WAVE 2010/Virtual Knowledge Centre 2011. UNICEF 2010

Table 3: Survivor Centered Attitudes and Methods

Survivor Centered Attitudes
Maintain a non-judgmental manner. Do not laugh or show any disrespect for the individual or her culture, family, or situation
Trust that she is the expert on her life and take your direction from her
Be patient. Do not press for more information if the survivor/victim is not ready to speak about her experience
Support her regardless the decisions she makes;
Believe her. Accept what the survivor is telling you. Do not dismiss her remarks as those of a "hysterical woman". Tell her you believe her
Believe each survivor has equal rights to care, support and protection
Believe each survivor is different and unique
Believe each survivor has different strengths, capacities, resources and needs
Believe each survivor has the right to decide who should know about what has happened to her and what should happen next
Ask only relevant questions. For example, the status of the virginity of the survivor/victim is not relevant and should not be discussed
Survivor Centered Methods
Treat her with dignity and respect
Avoid requiring the survivor to repeat the story in multiple interviews
Use affirmation. A calm, affirming and supportive reaction can foster a survivor's/victim's trust and disclosure.
Make sure she knows her rights and responsibilities;
Support her to identify and express her needs;
Support her to take decisions and choose a course of action
Reinforce her capacity to make decisions

CHILD-CENTRED REFERRAL SERVICES

Child means a person who is under the age of 18 years, but does not include a child who is or has been married
(CWA 2017 Part 1)

Any person who has reasonable grounds to suspect that a child may be in need of care and protection may report the matter to a social welfare officer or a police officer.
(CWA 2017 Division 2 Section 18)

The MoH NCPG outline processes for a child-centred approach (see section 3.3.7) including:

- psychological first aid for children and families
- informed consent and assent
- medical interviews
- medical interviews for children under the age of four
- asking children about child abuse
- asking adolescent boys about abuse
- how to deal with quiet children who do not want to talk
- processes for history taking
- medical examination of a child's
- details of mandated reporting of suspected child abuse by health workers
- completing a child abuse report

A child-centred approach: *the needs of child survivors differ from adult survivors in many ways and require some unique strategies for managing their medical care. Children who have been physically or sexually abused or exploited are dependent on adults for protection, basic needs, medication adherence, and access to follow-up care. A culture of secrecy and silence is compounded by the fact that most abuse occurs within families. Often such problems are considered private family matters and are hidden from outside scrutiny.*
(PEFAR, 2013)'

Child survivors are not treated as "little adults or dismissed as too young to understand or participate in treatment. Rather, child's rights, developmental level and special needs are taken into consideration during the interventions these include:

- Providing child friendly spaces;
- Using developmentally appropriate communication skills;
- The ability to engage caregivers in the child's treatment in a manner that ensures the Child safety and supports the child's recovery and healing process.
  (see page 16 MoH National Clinical Practice Guidelines)

Table 4: Definition of Child in Need of Care and Protection

A child in need of care and protection is a child who:
a. has been orphaned, abandoned or is without parental care and appropriate arrangements have not been made for his or her care; or
b. lives in an unsafe environment which may harm his or her physical well-being and development; or
c. has been displaced, traumatized or separated from his or her family as a result of an emergency, natural disaster or conflict; or
d. has been or is at risk of: i. physical abuse; or ii. sexual abuse or sexual exploitation; or iii. emotional abuse; or iv. neglect; or v. hazardous or exploitive labour.
(CWA 2017 Part 1 (5)

Table 5: Decision Making Principles Re: Children in Need

In making an order or taking any action in relation to a child under this Act, a person must consider the following principles:
• every child should be cared for and protected from harm;
• the preferred environment for the care and upbringing of a child is their own family;
• families and community should be assisted and supported in taking action to respond to concerns about the well-being and protection of the family, and the intervention of the court should be used only in circumstances where the child is unable to appropriately care for and protect the child;
• the child and all relevant family and community members except if their participation would be detrimental to the best interest of the child, should participate fully in deciding what action should be taken to promote the well-being and protection of the child;
• decision should be reached by collaboration and consensus wherever practicable;
• decisions relating to a child should be made and implemented in a timely manner;
• every child that is of such an age, maturity and stage of development as to be able to participate in any decision concerning that child has the right to participate in an appropriate way, and views expressed by the child must be given due consideration;
• any decision in relation to a child must be appropriate to the age of the child, the child's gender, any disability the child has, and the circumstances, religion and cultural background of the child;
• the well-being and best interest of the child must be a primary consideration;
• the rights of the child under the Convention on the Rights of the Child should be promoted and respected to the extent possible.
CWA 2017 Part 2 Section 11 - Decision-making principles

Section IV: SAFENET Minimum Standards

SAFENET MINIMUM STANDARDS OF COORDINATED RESPONSE AND REFERRAL FOR SURVIVORS OF SGBV

The ten (10) SAFENET MINIMUM standards negotiated and agreed by SAFENET members aim to standardize professional practice in SGBV referral and response. They follow regional and international best practice. All SAFENET members agree to adhere to the standards, to use them to guide their behavior, interventions and assistance (see Graphic 7).

1. Minimum standard on referral and coordination
2. Minimum standard on safety in response and referral
3. Minimum standard on confidential professional practice
4. Minimum standard on informed consent
5. Minimum standard on accompaniment and follow-up (case management)
6. Minimum standard on skills and training to standardize SAFENET response and referral
7. Minimum standard on perpetrator accountability
8. Minimum standard on accountability of SAFENET response and referral services
9. Minimum standard on accessibility of SGBV services
10. Minimum standard on SGBV prevention and advocacy

GRAPHIC 7: SAFENET Minimum Standards of Professional Practice for Referral and Coordination

1. MINIMUM STANDARD ON REFERRAL AND COORDINATION:

SAFENET operates in a multi-sectoral context and uses a formal referral and coordination system. The SAFENET response and referral pathway outlines the broad framework of direct response and referral within SAFENET. Survivors have the freedom and the right to disclose a violent incident to anyone. She may disclose her experience to a trusted family member or friend, an organization in the community, a health clinic, or she might choose to seek help in the form of shelter, legal protection and/or redress by making an official "report" to the police. There are range of entry points in the SAFENET direct response and referral system offering seven (7) key support services: medical, mental health, shelter, welfare/child protection, counselling, legal and para-legal, and police.

The referral pathway documents the referral procedures for SAFENET members. Regardless the entry point for reporting all SAFENET agencies will follow the six (6) step Immediate Response Actions: using a private room to talk, obtaining informed consent from the victim/survivor, offering first line crisis support/ Psychological first aid, ensuring immediate medical first aid/treatment including accessing essential medicines after rape; asking the three mandatory risk assessment questions and if the case is categorized as high risk doing basic safety planning and finally offering referral options of case management services or direct services.

The immediate response actions identified in the referral pathway represent a common/integrated approach by SAFENET members. All referred cases require that service provider to fill in the SRF.

2. MINIMUM STANDARD ON SAFETY IN RESPONSE AND REFERRAL:

SAFENET members use a safety first approach for all survivors/victims, their families and practitioners. A safety first approach recognizes there can be risks and dangers when responding to reported cases of domestic violence. It means safety is the first thing to be addressed. Each survivor/victim will be assessed for risk and danger associated with their case at the first point of entry. Service providers will work to protect survivors/victims from further physical and psychological harm, ensuring their actions do not further increase risks. This is in line with DO NO HARM. SAFENET will work toward a fast track system as part of its safety first approach.

3. MINIMUM STANDARD ON CONFIDENTIAL PROFESSIONAL PRACTICE:

SAFENET members practice total confidentiality for the safety and protection of survivors/victims. Breaches to confidentiality can put the victim/survivor and others at risk of further harm. Privacy must be ensured during interviews and support. Each agency will treat survivor assessment information confidentially within their agency and throughout the referral process. Information will be shared on a 'Need to Know Basis' and will only be shared with individuals and/or organizations providing assistance, or as requested and agreed by the survivor/victim. General SGBV incident data that is shared between agencies and/or used to understand prevalence and response will be non-identifying. All written information will be kept in secure, locked locations.

Total confidentiality does not apply if there is an overriding public interest, for example, a serious imminent risk to the life and safety of a person. The FPA requires that confidentiality be broken when the patient is under the age of 18 years old and if a health worker suspects that the child is a victim of child abuse. The health worker must report suspected child abuse to the social welfare division or the police and consent is not required. Reporting is not mandatory for adult survivors (18 years and above).

4. MINIMUM STANDARD ON INFORMED CONSENT:

All SAFENET members will obtain informed consent from victim/survivors before treatment/ delivery of service. Victims/survivors will be informed of all options including the risks and benefits of choosing each option and of the right to decline services. Survivors/victims' permission will be sought to provide services, collect and store data, to start case management, to be referred and to share information.

5. MINIMUM STANDARD ON ACCOMPANIMENT AND FOLLOW-UP:

SAFENET will offer case management support to victims/survivors. The service recognizes the value of someone to guide, support, accompany, follow-up and track victim/survivors through the system until their case is closed. It is a collaborative process between the case manager and victim/survivor to assess, plan, facilitate and advocate for options and services to meet a victim/ survivor's immediate and secondary needs. It uses a strengths based approach to identify and acknowledge the victim/survivor's strengths and to plan around and build on them through the process toward recovery. The type of intervention depends on and is shaped around the needs of each victim/survivor.

6. MINIMUM STANDARD ON SKILLS AND TRAINING TO STANDARDIZE SAFENET RESPONSE AND REFERRAL:

SAFENET training and orientation workshops will be implemented regularly (annually) to ensure members are up to date on and able to implement the Minimum Standards for referral and coordination. Training will be in line with established competencies that reflect the roles and responsibilities of SAFENET frontline service providers and case managers in the referral and coordination of SGBV services for survivors. Training modules are shaped around core competencies to implement the 10 Minimum Standards.

The identified competencies should inform all training so it develops core skills:

- The gender and human rights based dimensions of violence;
- The prevalence, causes and impacts of gender-based violence in the Solomon Islands;
- The policy and legal frameworks related to gender-based violence in the Solomon Islands
- How to implement and survivor centered - strength based approach;
- How to provide first support, including psychological first-aid and effective communication skills;
- How to obtain informed consent and explain survivor rights,
- How to implement privacy and confidentiality protocols;
- How to undertake intake and risk assessments;
- How to do safety and action planning;
- How to refer onwards and provide safe accompaniments support;
- Public prevention messaging in line with zero tolerance for SGBV

7. MINIMUM STANDARD ON PERPETRATOR ACCOUNTABILITY:

As part of zero tolerance for VAWG, SAFENET members will hold perpetrators accountable for their violence. Ensuring greater perpetrator accountability aligns with the objectives of the FPA which criminalizes domestic violence. Specifically, SAFENET members will advocate that the police (and courts where applicable) issue and enforce police safety notices and protection orders (interim and final). Perpetrator accountability means pursuing the offender and working with SAFENET partners to support prosecution provided this is the choice of the survivor. It requires swift action by the police and courts, and monitoring the implementation of court and police conditions.

8. MINIMUM STANDARD ON ACCOUNTABILITY OF SAFENET RESPONSE AND REFERRAL SERVICES:

CARECOM will use the 10 Minimum Standards as a framework to hold service providers accountable. The accountability framework with the 10 minimum standards can also be used to assess organizations requesting membership into SAFENET. It acts as a guide in cases of conflict of interest, dual loyalty or wontok, priority shall be given to the protection and well-being of the survivor/victim. The interests of the survivor/victim will take precedent over the interest of the organization or community.

9. MINIMUM STANDARD ON ACCESS TO SGBV SERVICES:

SAFENET members will be guided by a NON-Discrimination approach. This means service providers do not discriminate on the basis of sex, gender, religion, age or ethnicity.. All survivors will be treated equally and have all possible options presented to them. No survivor will be discriminated against or blamed. Service providers will strive to support survivors with persons of the same sex, culture and language. Regardless a survivor's history and/or the number of times she has accessed services she will be given the same respect and care as the first time. Service providers will advocate for equal access to justice remedies for survivors and for perpetrators (regardless of community status). In recognition of a survivors/ victims right to quality SGBV services across the country, the Solomon Island Government (SIG) and SAFENET members will work toward making SAFENET a national network, available in all 9 provinces and Honiara City Council.

10. MINIMUM STANDARD ON SGBV PREVENTION AND ADVOCACY:

SAFENET members will engage in and/or support prevention and advocacy programs to challenge harmful gender norms and facilitate a broader understanding of gender equality and power relations that respect the rights of women and girls. This is in line with the FPA requirement for public awareness programs aimed at preventing domestic violence and the health sector policy minimum standard on advocacy and awareness and prevention in the health sector.

SAFENET members have ZERO TOLERANCE of VIOLENCE AGAINST WOMEN and GIRLS, and publicly condemn violence as a violation of a woman's basic human rights. A zero tolerance stance requires that service providers challenge cultural practices that that are harmful to women and girls. SAFENET members will work to develop standard prevention and advocacy messages in line with the zero tolerance position of the network. Members will utilize agreed upon public advocacy messages.

Details of the Minimum Standards

1. MINIMUM STANDARD ON REFERRAL AND COORDINATION:

SAFENET operates in a multi-sectoral context and uses a formal referral and coordination system. The SAFENET response and referral pathway outlines the broad framework of direct response and referral within SAFENET. Survivors have the freedom and the right to disclose a violent incident to anyone. She may disclose her experience to a trusted family member or friend, an organization in the community, a health clinic, or she might choose to seek help in the form of shelter, legal protection and/or redress by making an official "report" to the police. There are range of entry points in the SAFENET direct response and referral system offering seven (7) key support services: medical, mental health, shelter, welfare/child protection, counselling, legal and para-legal, and police.

This system recognizes that survivors/victims often have multiple needs and cannot be supported by one agency alone and so need to be referred. The formal referral and coordination system is in line with:

- The FPA requirement that health workers, police officers and prosecutors refer victim/survivors onwards to support services;
- The CWA enabling the SWD to enter into agreements with other organizations or persons for the provision of child and family welfare services; and obliging them to establish a system for inter-agency referrals and coordination to ensure children in need of care and protection are identified and appropriate action is taken;
- The RSIPFs Commissioner Order on Family Violence (CO/2016/NO/003) requiring police officers to assist victims to obtain a Public Safety Notice (PSN) and/or Protection Order (PO) and to access a place of safety in the community and/or counselling, medical or legal services; requiring family violence coordinators in each province to work with the police commander to engage with agencies that are able to provide appropriate and timely support for victims; and, requiring RSIPF to refer victims to appropriate available services noted above as safe shelter, medical, legal or counselling; and
- Policy Minimum Standard 3.4 for Onward Referral in the NCPG for the MoH obliging all healthcare professionals to refer survivors of violence on to other services, following a standardized procedure through SAFENET, to ensure their immediate safety and to reduce future risk

THE REFERRAL PATHWAY (ANNEX 2)

The referral pathway documents the referral procedures for SAFENET members. Regardless the entry point for reporting all SAFENET agencies will follow the six (6) step Immediate Response Actions: using a private room to talk, obtaining informed consent from the victim/survivor, offering first line crisis support/ Psychological first aid, ensuring immediate medical first aid/treatment including accessing essential medicines after rape; asking the three mandatory risk assessment questions and if the case is categorized as high risk doing basic safety planning and finally offering referral options of case management services or direct services.

The immediate response actions identified in the referral pathway represent a common/integrated approach by SAFENET members. All referred cases require that service provider to fill in the SRF.

PURPOSE:

A central aim of the coordinated system is to avoid re-victimizing the victim/survivor through duplication and repetition such as asking questions more than once. The processes focus on gathering relevant information only. Members must have knowledge of all of the SAFENET services and use the formal referral process with the referral form. Referrals can only be made after receiving written consent from the victim/survivor.

REFERRAL PROCESS

There are three (3) steps in the referral making process:

STEP 1 - OBTAIN INFORMED CONSENT FOR REFERRAL AND PREPARE THE VICTIM/SURVIVOR

Before referring victim/ survivors to other services, SAFENET direct service provider/ case mangers need to obtain informed consent for doing so (see Minimum Standard #4 below). Once informed consent is obtained contact the agency focal point to give advance notification of referral (see Annex 3 SAFENET Contact List).

STEP 2 – MAKE ACCOMPANIMENT PLANS FOR THE REFERRAL

Victim/survivors being referred should have access to accompaniment support. The CWA and RSIPF CO/2016/NO/ 003 require that all children be accompanied through the referral process. Accompaniment support for children (under the age of 18) will be provided by social welfare and/or police officers depending on the point of entry. The aim of accompaniment support under CWA is to ensure children in need of care and protection are supported through actions such as removal and relocation to a temporary safe place. When a police officer concludes that a support service or other means of care is required for a child they must make the necessary arrangements to ensure safe transport care of the child to a responsible family member, particular agency or specialist.

Adult victim/survivors can access accompaniment support if they choose case management support. The intake officer at the point of entry will include in the explanation of case management support information about accompaniment. Accompaniment will safeguard the victim/survivors' confidentiality by:

- Using persons identified as appropriate to accompany the survivor (i.e. trained case managers/ service providers/volunteers)
- Using known transport vehicles - either a SAFENET member transport vehicle (preferably with darkened windows) or known taxi companies with trusted drivers;
- Using the SAFENET referral form with non- identifying information, secured in a sealed envelope. The referral form will be handed directly to the contact point at the referred to service provider agency. The referral form may also be shared electronically through email marked confidential directed to the contact point at the service provider.
- Remember - Information will only be shared internally and externally on a 'Need to Know Basis' and only with individuals and/or organizations providing assistance and as requested and agreed by the survivor (see Minimum Standard #3)

Table 6: SAFETY PROCEDURES SAFENET CASE MANAGEMENT Services

Case Manager/Driver Safety Log A means for the FSC to monitor the safety of the case manager team while they are in the field. A case manager lets the receptionist know where they are going and approximately how long it will take to complete the activity. The receptionist will check in with the case manager by phone if she has not heard from the case manager. See Case Manager Safety Log Procedure (Annex 5).
Case Manager/Driver Safety Log Procedure Outlines the procedure for providing safety checks on the activities of case managers and FSC drivers who are in the field (Annex 4).

STEP 3 – DOCUMENT THE REFERRAL CHOICE ON THE SAFENET REFERRAL FORM.

- Once the intake officer at the entry point and the victim/survivor have gone through the 6 immediate response actions in the referral pathway, the intake officer should document everything in the SAFENET Referral Form (Annex 6)
- Ensure the relevant consent forms are signed for the referral process

THE SAFENET REFERRAL FORM

The SAFENET referral form summarizes basic non-identifying information about each incident of SGBV reported at any entry point and being referred onward to another SAFENET service provider. **All** SAFENET service providers referring cases onward must fill out the SAFENET referral form.

SAFENET REFERRAL FORM PURPOSE

The purpose of the SAFENET referral form is to highlight basic information required by all SAFENET service providers and to reduce the number of times that a victim/survivor has to tell their story. The information is summarized from the client file opened at the entry point where the case is reported.

The SAFENET referral form begins with a client identification number, followed by seven (7) sections.

Section 1 summarizes information of the risk category flagging high-risk cases in red and safety concerns. It records the answers to the mandatory three risk assessment questions determining high or low risk.

Section 2 summarizes referral and direct service details beginning with information about the service(s) provided, including time and date, and the referral service required.

Section 3 summarizes non-identifying client information and is aligned with SAFENET member intake information needs (see Annex 7 for RSIPF basic information needs). Non-identifying information removes any information that can identify a client, for example name, address and telephone number. The information is removed for safety purposes. This section provides summary information about the history of violence and the number of times, if any, that the client has reported in the past. It indicates whether the client has granted permission for the service provider to contact them and the details of how to make contact. This is a safety-related question to ensure service providers do not place the client at increased risk of harm. Phone calls or home visits can place a client in harms way if the perpetrator discovers that s/he has reported.

Section 4 summarizes non-identifying incident and perpetrator information. Like the section above it removes all identifying information about the perpetrator for safety purposes. It includes additional safety related information with questions about aggravating factors such as weapons, alcohol and drugs in the violent incident.

Section 5 indicates if informed consent and permission to share information have been obtained. If the answer to either of these questions is **No** than informed consent should be obtained from the client before proceeding. **No responses** should also be reported to the SAFENET coordinator for follow-up action with the service provider.

Section 6 summarizes client goals that make up individual action plans.

Section 7 summarizes the name end date of the service provider, as well as the name and contact details of the case manager appointed to the client.

SAFENET Response and Referral Pathway

Survivor Seeks Help from one of the SAFENET Providers:	
• Medical Services (NRH/HC/Seif Ples/ANC)	• Integrated Mental Health (MHS)
• Shelter (CCC/Seif Ples)	• Social Welfare Division (SWD)
• Police	• Family Support Center (FSC)
	• Legal (PSO)

Immediate Response Action used by all SAFENET Entry Points

Private Room to talk Safe/Caring environment	Informed Consent	First-line crisis support Psychological First Aid	Medical First Aid and **if less than 3 to 5 days since rape incident, access Essential Medicine quickly	Mandatory 3 Risk Assessment Questions Yes Response Flags High Risk Case And Mandatory Safety Planning	Offering Referral Options: 1. Case Management (for further assessment and support) or 2. Direct Referral to SAFENET Partners for service * Fill out SafeNet Referral Form

SAFENET Case Management Services call 26999 or 20619 (24 Hours)

- Case Manager comes to the survivor at the SAFENET entry point to offer services and support
- Case Manager completes a needs assessment and develops an Action Plan with the survivor
- Case Manager provides accompaniment and support until survivor's goals are met.

*SAFENET Referral Services

Medical Services	Mental Health	Shelter	Welfare / Child Protection	Counseling	Legal & Para-Legal Information	Police
If the survivor • Has physical injuries or • Has been sexually assaulted or raped Rape is a medical emergency. It is best to get all medicines within 3 days of the rape.	• If the survivor appears to be a danger to him/ her self or others (e.g. suicidal or violent) • If you suspect that the client has a mental disorder • If the client remains disoriented or unresponsive after PFA has been given.	• If the client is too afraid to return to their home. • If the perpetrator is waiting for the survivor and she is afraid to leave. • If the survivor reports perpetrator is continuing to threaten to harm her or others.	• If you are a health care worker and suspect that a child has been abused, the Family Protection Act (FPA) requires that you make a report. • If a child has been abused and it is unclear if the caregiver can keep the child safe.	• If the survivor requests counseling or emotional support • If the survivor continues to be overwhelmed after receiving basic first-line support/PFA • If the survivor is a child or disabled person and the guardian/parent does not appear supportive. • If the survivor is not functioning in their daily tasks or routine.	• If the survivor needs Information about legal options • If the survivor needs legal assistance with • maintenance, • divorce, • custody	If the survivor needs • immediate protection • help to return to her home to collect personal items • Police Safety Notice
1. National Referral Hospital Emergency Department 2. Health Centers: Gender Focal Points 3. Seif Ples Model Sites	1. Integrated Mental Health Service at NRH 2. In Provinces -Mental Health Focal Point	1. Seif Ples Model Sites • Short stay:1-3 days 2. Christian Care Center • 1-2 weeks	Social Welfare Division Child Abuse Reporting Child Protection Services	1. Family Support Center • Empowerment Counseling • Therapeutic Counseling: 2. IMHS 3. Pastoral/ spiritual counseling at CCC or various churches	1. Public Solicitor's Office 2. Family Support Center 3. Authorized Justices	Police • 24 hour 999/23666 • Central Police 22266 • Henderson 36200 • Family Violence Unit 28275

In provinces see local referral pathway, where available, for services

2. MINIMUM STANDARD ON SAFETY IN RESPONSE AND REFERRAL:

SAFENET SAFETY PROTOCOL INTRODUCTION

SAFENET members use a safety first approach for all survivors/victims, their families and practitioners. The protection and safety of all persons who experience or witness domestic violence is a primary concern in the FPA. The law aims to promote the safety, health and well-being of victims/survivors in efforts to stop domestic violence. Safety is the basis of the Police Safety Notices (PSN) and Interim and Final Protection Orders (IPO / FPO). The RSIPF CO/2016/NO/003, the CWA and the NCPG 2016 outline practices and procedures to protect and reduce risk to both the victim/survivor and the service providers (Sector Specific safety and risk procedures Annex 8).

A safety first approach means safety is the first thing to be addressed. Each survivor/victim will be assessed for risk and danger associated with their case at the first point of entry. Service providers will work to protect survivors/victims from further physical and psychological harm, ensuring their actions do not further increase risks. This is in line with DO NO HARM. SAFENET will work toward a fast track system as part of its safety first approach in line with both the CWA and the RSIPF CO/2016/NO/003.

SAFETY PROTOCOL PURPOSE

The SAFENET safety protocol recognizes there can be risks and dangers when responding to reported cases of domestic violence. The protocol specifies that each survivor/victim will be assessed for risk at the first point of entry, as per the SAFENET Referral Pathway (see Table 9). The 3 mandatory safety questions enable the entry point service provider and case manager to assess immediate threats, risk and danger to the victim/survivor and to the service provider. The responses will provide critical information to help determine priority actions. It is important to note that the 3 mandatory questions are different than the in-depth risk assessment which can be administered in cases determined to be High Risk.

Table 9: SAFENET Immediate Response Actions

Immediate Response Action used by all SAFENET Entry Points					
Private Room to talk Safe/Caring environment	Informed Consent	First-line crisis support Psychological First Aid	Medical First Aid and **if less than 3 to 5 days since rape incident, access Essential Medicine quickly	**Mandatory 3 Risk Assessment Questions** Yes Response Flags **High Risk Case** and **Mandatory Basic Safety Planning**	Offering Referral Options: 1. Case Management or 2. Direct Referral to SafeNet partners for service ** fill out SafeNet referral form

Safety Protocol Process

The protocol involves five (5) steps (see Figure 1 for Safety Protocol Pathway):

Step 1: Ask 3 questions to determine immediate risks for survivor and service provider: All SAFENET members ask the 3 risk assessment questions (see Table 10). For Yes responses to Question 1 notify your supervisor and call the police to the site.

Table 10: SAFENET Mandatory Risk Assessment Questions

SAFENET Mandatory 3 Risk Assessment Questions		
1.	Does the perpetrator know where you are right now? If yes, do you think he will try to find you here? **If the answer is yes, notify your supervisor and call the police to the site.**	Yes / No
Explanation: If the answer to this question is yes, this will require immediate safety planning. Perpetrators who follow the victim/survivor and/or who have interfered with the her/him reporting in the past may pose a risk for the victim/survivor, the staff and other victim/survivors on site.		
2.	Will you be in immediate danger when you leave here? If yes, what kind of danger do you think you will face when you leave here?	Yes / No
Explanation: If the client has been assaulted or raped or assaulted by someone living in the same house they may not be able to return home.		
3.	How safe do you feel at home right now? On a scale of 1-5, 1 = very safe; 5 = not safe at all	1 - Very Safe 5 - Not safe at all
Explanation: If a client is experiencing domestic violence, they will need to carefully think through safety options if they returns back to the home. **Safety at home** Draw the diagram below on a separate piece of paper so that the victim /survivor can see it. Use the scale to ask the victim/ survivor how safe she feels at home. You can also use the 'smiley' faces to ensure that the victim/survivor understands the progression of the scale. 1_____5 (with smiley faces) **Example explanation of diagram** I'd like to find out how safe you feel at home right now. Here is a picture that will help us. On one end is the number 1 and a frowning face or sad face - this means you do not feel safe at all at home. All the way at the other end is a number 5 and a smiling or happy face - this means that you feel perfectly safe at home. I'd like you to show me how you feel right now at home - between 1 and 5 by pointing to the number that best describes how you feel" Get more information about why the victim/survivor chose the number they did. For example, can you tell me why you feel that way or can you tell me why you chose that number.		

Step 2: Categorize risk and offer case management support: A 'Yes' response to questions 1 and 2; and scores 4-5 on the safety scales flag the case as High Risk. All clients with High Risk cases should be advised that the case management service provides additional support, including a detailed risk assessment (Step 6) and safety planning (Step 4). Case mangers will be refer High Risk cases to a case conference within 3 -4 working days.

High Risk: Cases in which the victim/survivor is at increased risk for more violence. With each additional 'Yes" to risk assessment questions the potential danger level increases. Response should be expedited, a case conference called and caution and safety planning used.

The RSIPF identifies High Risk cases as those where

there is a probability of confrontation with the person who is armed or is reasonably suspected to be armed with a firearm or other lethal weapon;

there offender has a prior history of significant violence;

the safety of a third party is at risk;

Low Risk: Cases when risk is less immediate. Clients will pass through the normal SAFENET system of response. Victim/survivors can be supported by examining their skills for coping with difficult feelings and thoughts, and if needed, developing a safety plan.

Step 3: Do basic safety planning: all High Risk cases require safety planning. If the client chooses:

- Option 1) case management support, the case manager will do safety planning with the client.
- Option 2) direct referral to SAFENET partners for service, the entry point officer must do basic safety planning with the client. (See Table 11 and Annex 9)
- In High Risk cases safety mechanisms must be put in place before the victim/survivor leaves the first point of entry.

Table11: Basic Safety Planning

SAFENET 6 Basic Safety Planning Questions		
	Question	**Action**
Identify danger		
1.	What are the warning signs of violence? (explanation of cycle of violence) What actions can you take?	
Safe Place to go		
2.	If you need to leave your place in a hurry, where can you go?	
Planning for children		
3.	Would you go alone or take your children with you?	

SAFENET 6 Basic Safety Planning Questions		
Transport		
4.	How will you get there?	
Items to take with you		
5.	Do you need to take any documents, phone number, keys, money, clothes or other things with you? Can you put these things in a safe place with someone, just in case?	
Support of someone close by		
6.	Is there a neighbor you can tell about the violence who can call the police or come with assistance for you if they hear sounds of violence coming from your home?	
Explanation: Safety planning enables the client to proceed with a pre-planned course of action in a life-threatening situation. It can help to minimize the potential harm done by the perpetrator by identifying resources, ways to escape, means to avoid harm, and places the client can go for safety (see full safety planning details below)		

Step 4: Fill out SAFENET Referral Form (SRF): Referrals to SAFENET case managers require the entry point service provider to fill out a SRF (see Annex 6) with non-identifying information. The service provider must give notice of High Risk cases on the referral form.

Table 12: Definition Non-Identifying

Non-identifying information removes all personal information about the client and perpetrator (name, address, contact number) from the form. This information is housed in individual case files, in a secure location, within the SAFENET member organization.

Step 5: Case managers conduct deeper risk assessment upon consent: SAFENET case managers notified of a High Risk case will do a detailed risk assessment as part of the intake process with the client form (Annex 10). If additional details of risk are needed an in-depth risk assessment form is available. This will be followed by safety planning using the SAFENET Safety Planning Form (Annex 11).

Note:

- SAFENET case managers do risk assessment and safety planning with all clients they support with consent.
- All SAFENET case managers follow the safety procedure in Table 13 for SAFENET case managers and drivers working out of FSC.

Table 13: SAFENET Case Manager/Driver Safety LOG Procedure

Step One: Any case manager or driver leaving to do FSC business needs to register their activity with the receptionist

Step Two: the receptionist documents the following items:

- Phone Contact – test if phone working and check if top up is needed
- Time of Departure
- Destination
- Anticipated return time: the receptionist will do a safety check if you are taking too long.

Step Three: The case manager/driver will call the receptionist if the plans or destination changes, or if the activity will take longer than anticipated.

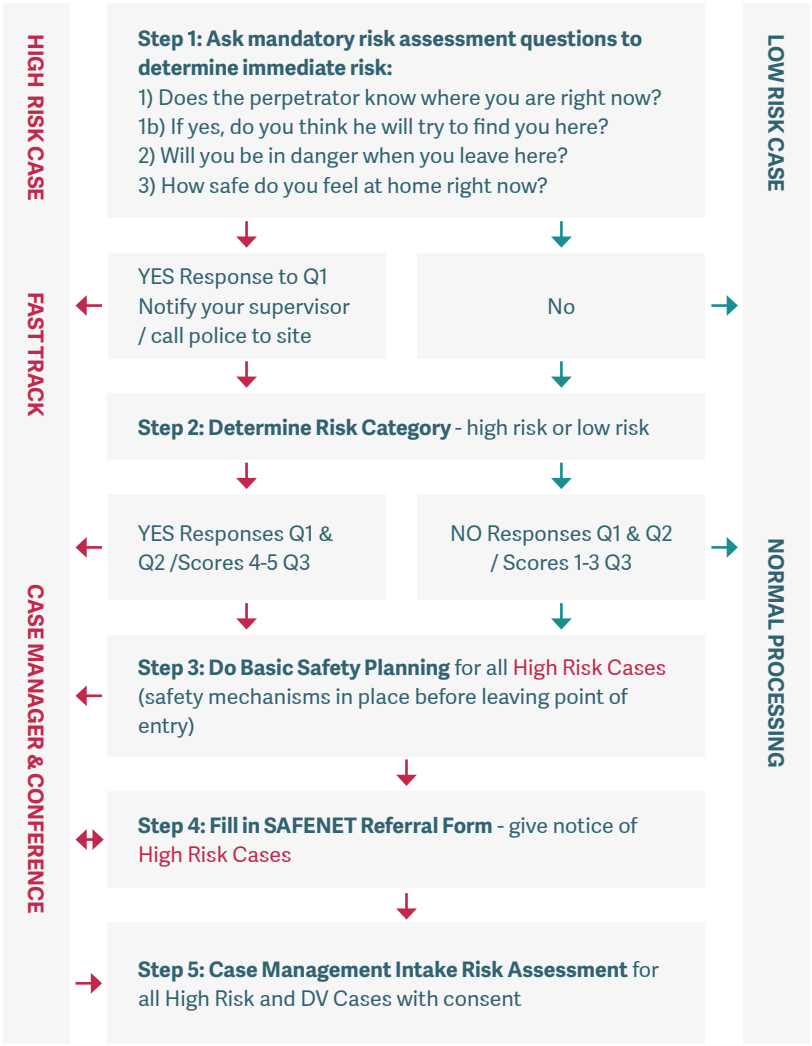
- The Safety Check-ins should happen every hour.
- If the case manager does not call, the receptionist will call and write down the time.

Step Four: When the case manager/driver returns, the time will be noted and no further follow up is needed.

Other follow up that may be needed:

- If the case manager or driver reports immediate danger,
  - ask for their location and stay on the phone with them,
  - Notify the FSC supervisor,
  - Call the Police
- If the case manager or driver do not appear to be comfortable for any reason (e.g. safety worries, people in the environment are not supportive, etc.)
  - Notify the FSC supervisor
  - Encourage them to return to the FSC for review of the Action Plan with the FSC Supervisor.
- If the receptionist needs to take her lunch break or to leave work early, she will hand over the log to another person to manage it until she returns.

Figure 1: SAFENET Safety Protocol Pathway



RISK ASSESSMENT QUESTIONS ON CASE MANAGEMENT CLIENT FORM

Risk Assessment Questions in Client Form			
RISK or VULNERABILITY FACTORS	**YES**	**NO**	**Notes**
Victim/ Survivor issues which may increase risk			
Who came with the client?			
Permission to contact?			
Status of bride price?			
Perpetrator location?			
Weapons used in current incident?			
Alcohol / drugs in current incident?			
Frequency of Problem			
Severity of the problem			
Duration of violence (first episode to now)			
Main presenting complaint (i.e. separation /divorce)			
Suicide Risk Assessment			
Violence risk assessment (toward others)			
Violence risk assessment (toward client)			
When was the last time you drank alcohol (marijuana, drugs)? How much and how often?			
Observed problems with thinking			

IN-DEPTH RISK ASSESSMENT

The in-depth SAFENET risk assessment form contains 29 questions to enable a detailed assessment; 11 are flagged (**) as essential to understand risk.. The questions focus on factors that may increase risk and vulnerability for the victim/survivor. The questions examine the behavior and circumstances of victim/ survivors, perpetrators and some relationship issues. They also include a question that enables the victim/ survivor to assess their own safety.

IN-DEPTH RISK ASSESSMENT PROCESS

Case managers or front line service providers can do a more detailed risk assessment (see step 6 in Fig. 1 above). Consent must be obtained from the victim/survivor before doing the more detailed risk assessment. It should be used for all high-risk cases, domestic violence cases and will be relevant for some rape cases if the assaults have been ongoing.

After asking the 29 questions the SAFENET case manager / service provider is required to answer 10 questions summarizing key areas of focus for client safety. These questions enable the case manager to determine the full level of risk again high risk or low.

High risk cases - If the service provider answers yes to any of the 10 questions the case should be considered **HIGH RISK**. Any "yes" answer could put the victim/survivor at increased risk for more violence. With each additional "yes", the potential danger level increases. The case manager should consider these factors when conducting the safety plan.

Low risk cases are cases when risk is less immediate. At this point, the case manager should support the victim/survivor by examining their skills for coping with difficult feelings and thoughts, and if needed developing a safety plan.

The category of risk should be identified in Section 1 of the SAFENET referral from. **All high-risk** cases require that the case manager and service provider discuss the option of a safety plan. Case mangers will be refer High Risk cases to a case conference within 3 -4 working days.

Case managers may be able to get some of the information for the risk assessment when the victim/ survivor tells her story. If she does not talk about these things, you should ask her these questions specifically so that you know the answer to each of the questions below, as they will help you in the safety planning.

Note: It is up to the service provider to determine whether they would use the form when asking the question, or whether they would record information after the meeting with the victim/survivor. You will be guided by the victim/survivor. It is important to get familiar with the risk assessment questions if not using the form.

IN-DEPTH RISK ASSESSMENT WITH EXPLANATION NOTES:

Below each set of questions is a brief explanation of the rationale for the questions.

Table 16: SAFENET In-depth Risk Assessment Form Guidance

Risk Assessment			
RISK or VULNERABILITY FACTORS	**YES**	**NO**	**Notes**
Victim/ Survivor issues which may increase risk			
Pregnancy / new born baby?			
Did the violence get worse during pregnancy?			
It is important to know if the violence is frequent and if it tends to escalate and become more severe over time.			
**Suffered serious injuries in past week?			

Risk Assessment			
RISK or VULNERABILITY FACTORS	**YES**	**NO**	**Notes**
If the perpetrator has caused one or more injuries in the past that could have killed or caused the victim/survivor to die. (If yes, the perpetrator is more likely to kill the survivor or hurt her so badly that she may die).			
Perpetrator lives in the same house?			
If the survivor has been assaulted or raped or assaulted by a someone living in the same house the survivor may not be able to return home. If a survivor is experiencing domestic violence, she will need to carefully think through her safety options if she returns back to the home.			
Depression / mental health issues?			
Has ever talked about or had suicidal thoughts or tried to commit suicide?			
Explain to the victim/survivor that you are going to ask some questions that may be difficult to answer but that you are worried about her and want to make sure she is ok. Ask some questions that will help you to assess her suicidal thought. For instance, Do you think about dying? Do you wish you were dead? Have you thought about hurting or killing yourself recently? Based on the victim/survivor response, and if you think there is a risk of suicide, you may need to make an immediate referral to a counselor. If the survivor answers no and there is no evidence to suggest the survivor is intending to harm or kill herself, it is likely that the risk of suicide or self-harm is low.			
Is isolated from family and friends?			
This is important to understand when doing safety planning. It can provide insight into emotional and psychological vulnerabilities. Trusted networks of family and friends will be important in devising temporary shelter and escape routes.			
Is fearful of the perpetrator?			(Very fearful or a little fearful?)
Has a safe place to stay?			Where?
A key question to help with safety planning .			
Perpetrator issues which may increase risk			
Gathering information about the alleged perpetrator helps in evaluating a victim/survivor's risks for future harm by the perpetrator and/or friends and relatives of the perpetrator. Each perpetrator has different patterns and identifying them is what makes a good safety assessment. Once the victim/survivor has identified patterns of violence, she can better plan, avoid, or respond. Some victim/survivors will already know what the patterns are; others will need your help to think through the situation and uncover them			
**Did the perpetrator use a weapon in most recent event?			
**Does the perpetrator have access to weapons? (guns, knives)			
**Has ever tried to choke the victim?			
Actions during the act of violence, including (weapons, choking or actions that cause one or more injuries that could have killed or caused the victim/survivor to die. (If yes, the perpetrator is more likely to kill the survivor or hurt her so badly that she may die).			
**Has ever tried or threatened to kill the victim/survivor?			

Risk Assessment			
RISK or VULNERABILITY FACTORS	**YES**	**NO**	**Notes**
Perpetrators who threaten suicide or homicide must be considered very dangerous. If the perpetrator has killed before in or out of combat, he may be more dangerous as well			
From what you might know about the situation do you think that the perpetrator is likely to act on the death threats?			
The victim/survivor knows better than anyone the behavior of the perpetrator. She is the one who best understands the danger she faces. She is the best person to assess her own safety with careful guidance.			
Has ever harmed or threatened to harm or kill children or family members?			
Has ever threatened or tried to kill himself/herself?			
Impossible to predict whether a perpetrator will seriously harm or kill the survivor, himself or another person. However, knowing the danger signs can help you to make an educated evaluation of the victim/survivor's vulnerability			
Stalking the victim/survivor?			
**Jealous and controlling behavior toward victim/survivor?			
He says he can't live without her; he is very jealous and accuses her of seeing other men; he closely monitors her activities and stalks her when she tries to do her own activities			
Sexual assault of victim/survivor?			
**Depression/mental health issues?			
This may mean he feels hopeless and could increase risk for threats to his own life and/or the victim/survivor's.			
**Drug and/or alcohol/kava misuse/abuse?			
This is likely to impair his judgment and many be a regular trigger for violence. Understanding the relationship to alcohol and violence can help with safety planning.			
Unemployed?			
Has the perpetrator been to prison?			
**Does the perpetrator have a history of violent behavior (toward community members, police)?			
**Does the perpetrator have a history of family violence?			
Involvement with violence in the past, including in combat, can be a risk factor for perpetrating other forms of violence			
Relationship issues which may increase risk			
Recent separation			
**Escalation - increase in severity and/or frequency of violence			
It is important to know if the violence is frequent and if it tends to escalate and become more severe over time.			

Risk Assessment			
RISK or VULNERABILITY FACTORS	**YES**	**NO**	**Notes**
Has ever interfered with victim/survivor reporting violence?			
No respect for the authority and controlling behavior can indicate increased risk for the victim/survivor and the service providers.			
Financial difficulties			
Victim/survivor assessment of their own safety:			
The victim/survivor knows better than anyone the behavior of the perpetrator. She is the one who best understands the danger she faces. She is the best person to assess her own safety with careful guidance.			
SAFENET member opinion of overall victim/survivor safety			
Is the perpetrator of abuse with victim/survivor now?			
Is victim/survivor afraid of the perpetrator?			
Is victim/survivor afraid to go home?			
Has physical violence increased in severity or frequency?			
Has the perpetrator ever physically abused children?			
Has the perpetrator ever sexually abused children?			
Is there a weapon in the home?			
Has the perpetrator ever been threatened to kill someone?			
Have there been threats of suicide by the victim/survivor?			
Have there been threats of suicide by the perpetrator?			

SAFENET Safety Planning

SAFETY PLANNING PURPOSE

Safety and protection from further harm and violence are the foundations of safety planning. Safety planning involves collaboration between the case manger and the victim/survivor to develop a plan that meets the victim/survivor needs. A safety plan should consider the safety of both the victim/survivor and the service provider.

If the victim/survivor answers yes to any of the mandatory 3 risk assessment questions and/or the case manager answers yes to any of the 10 summary questions in the detailed risk assessment questions safety planning is required to avoid placing the victim/survivor and/or service provider in danger (see Safety Protocol Fig. 1, Annex 10 and Table 16 In-depth Risk Assessment).

The purpose of Safety Planning is to enable a victim/survivor to proceed with a pre-planned course of action when she is in a life - threatening situation. It can enable the victim/survivor to minimize the potential harm done by perpetrators by identifying resources, ways to escape and avoid harm, and places the victim/survivor can go for safety. Safety planning is an important tool to help victim/survivors to develop, use and trust their problem-solving and thinking skills. The victim/survivor best understands

the perpetrator, his violent behaviour, and what strategies will work. Case mangers need to work with the victim/survivor to ensure she is comfortable carrying out the components of the safety plan.

At any one time the safety plan developed will respond to immediate needs. It is important to recognize that circumstances may change and safety plans should be revisited if there is another incident of violence. Safety planning decisions should be driven by the victim /survivor. If the victim/survivor needs to be referred to other services for support consent must be obtained.

SAFENET SAFETY PLANNING PROCESS

In High Risk cases safety mechanisms must be put in place before the victim/survivor leaves the first point of entry (see Table 11 above). The basic safety planning form has been developed to enable all service providers to ask High Risk clients 6 safety planning questions. All case managers will encourage safety planning with clients.

All safety planning, (basic and more in-depth) involves three steps (see Table 17).

Table 17: SAFENET Safety Planning 3 Step Process

SAFENET Safety Plan 3 Step Process
Step One: Identify the victim/survivor's existing resources, coping mechanisms and safety strategies
Many victim/survivors have safety and coping mechanisms in place already. The key is to find out what is already working for the victim/survivor and build upon it. Below are a list questions to help identify what the victim/survivor currently has in place for safety and what you need to further identify.
Step 2: Help the survivor identify and think through options. Part of planning for safety is helping victim/survivors think through the process of leaving their situation or staying (whether on a temporary or permanent basis). Every option will have risks that need to be discussed. A decision to pursue one option over another must be carefully thought through, anticipating and weighing the risks. For any of these options, the case manager should also practice with the victim/survivor how she will respond to contact with the perpetrator and when she perceives immediate danger.
As the victim/survivor begins to identify potential responses and resources, help her to plan exactly what she would do in each of the threatening situations. After she has identified all the resources she has, you can begin to discuss how they can be appropriately applied to dangerous situations. Usually, a victim/survivor will have a more moderate plan for less threatening situations and a more drastic one for life-threatening situations. The most dangerous time for any survivor of intimate partner violence is when she tries to leave an abusive situation, so she should know exactly at what point she is going to leave and where she is going to go.
Step 3: Based on the identified safety risks, the case managers knowledge of resources in the community, and the victim/survivor's knowledge of her situation and existing assets, the case manger will determine with the victim/survivor what course of action she will take and develop the safety plan together. The case manager will document the plan.

Table 18: SAFENET Case Manager Safety Planning Form (Annex 11)

Safety Planning		Steps to take:
Identifying Danger	What are the warning signs? When do you take action? (Cycle of Violence)	
Safe Place to go	If you need to leave your home in a hurry, where could you go?	
Planning for Children	Would you go alone or take your children with you?	
Transport	How will you get there?	
Items to take with you	Do you need to take any documents, phone numbers, keys, money, clothes, or other things with you when you leave?	
	Can you put together items in a safe place or leave them with someone, just in case?	
Financial	Do you have access to money if you need to leave? Where is it kept? Can you get it in an emergency?	
Support of someone close by	Is there a neighbor you can tell about the violence who can call the police or come with assistance for you if they hear sounds of violence coming from your home?	

Table 19: Additional Questions to Assist with Safety Planning Guidance Notes

SAFENET Safety Plan Notes
Step One: Identify the victim/survivor's existing resources, coping mechanisms and safety strategies
What do you do when you are in danger? Help her to think about alternative responses.
Where do you go? Help the survivor to think of at least one safe place she can run to in an emergency. She should arrange things with that place ahead of time.
Whom do you trust? Think about anyone (neighbors, friends, family members, an organization) that the victim/survivor can trust. For example: discuss having a signal with helpful neighbors, a safe word. Upon seeing this signal from the victim/survivor, neighbors would plan to visit in a group.
What local authorities or police might you involve, and under what circumstances would you involve them? It is best if the victim/survivor decides on a point at which she will report the perpetrator and involve authorities.
Is there anyone who can talk to the perpetrator at a nonviolent time to try to discourage his violence? There may be someone whom the perpetrator respects that could work with him to change his behavior
Who already knows about your partner's abuse? The survivor may not be embarrassed to enlist the help of these people.
What financial resources do you have? Consider saving money and hiding it somewhere he will never look, or keeping at the designated safe place with other important documents, such as phone numbers, medication, bank cards and an emergency contact list.
What material resources do you have? Can any of these be moved out of his reach? Can any of them be used to support the victim/survivor if she needs a means of income?

SAFENET Safety Plan Notes
If you have to leave, what will you bring? Consider important documents, clothing, food, and money and how it will be moved.
How can you involve your children? What do your children do when you/they are in danger? How do you and your children plan safety together?
If you have to leave, what will happen to your children? If the victim/survivor has children, what will be their role in the escape? Be aware of their safety and how much they are able to handle.
Who else might be in danger if you had to leave? Consider whether the perpetrator would take out his frustration on anyone else if the victim/survivor left.
How can you protect against weapons? If there are weapons in the house, the victim/survivor should know where they are and try to put them in hard-to-access places. If there are guns, the victim/survivor should have someone teach her how to unload them and she should keep the ammunition in a separate place. If she can, she should guide the fight away from areas where she knows there are weapons or potential weapons (like kitchen knives, hot pans, etc.).
Step 2: Help the survivor identify and think through options.
Decision to return home: • Develop a safety plan that she can draw upon when back home that is about minimizing risk for further harm. • refer back to the safety assessment and the questions about existing resources to guide that discussion. • What are the signs she can see in your husband's behavior that let her know that he may be violent towards her? • Can she get out of the house before the violence starts or send a signal to someone for help? • Is there a signal she can create to let neighbors know that she needs help? • Are there weapons in the house? Can she remove or hide them? • Are there places in the house that can provide some safety? • Discuss the risk of escalating violence
Decision to go to a safe house: • This option needs to be considered carefully with the victim/survivor as it could put her at risk for further harm when she tries to leave. • Discuss the following with the victim/survivor: • Does she have what she needs to go to the shelter now? If not, how will she safely get items such as identification, important documents, or money? • Will she take her children with her? If so, how will her children get there safely? What does she need to bring for her children? • Does she know what she can expect at the shelter/safe house? How long can she stay?

SAFENET Safety Plan Notes
Decision to seek temporary shelter: • Explore with the victim/survivor whether or not she has her own safe place that she can go to temporarily for respite. • This can be a good option if the survivor is not ready to go to a shelter but needs to get out of her house. • There are also risks associated with this option that must be considered. • Consider the following questions to guide the safety planning around this option. • What are the risks for her of staying at someone else's house (e.g. will the perpetrator come there to find her?)? • Will she take her children with her? If so, how will she her children get there safely? What does she need to bring for her children? • How will she keep herself safe if she needs to leave the house to get something or do something?
Step 3: Based on the identified safety risks course of action documented (see Annex 12 for additional tips for safety Planning)
Call police
Accompaniment by police / other service providers
Trusted neighbor / family who can call police
Identify an agreed safe word for communication
Sharing safe words with trusted neighbor/family/children
Safe place in home away from weapons
Emergency exits in home
Emergency pack of important documents (money, phone numbers, medication, bank cards)
Temporary shelter options in her network
Emergency escape plan
Impacts of violence in children
Safety plan and children
Emergency contact list for services (police, legal, shelter, counseling, medical) and keeping it safe
Risks of escalating violence with a violent partner
Interim protection orders and breaches
Public Safety Notices and breaches
Risks associated with reporting violence and leaving a violent partner
Strategies to help children to cope
Confidentiality and possible breaches
Safety plan notes (include information about other services to be contacted & contact details

3. MINIMUM STANDARD ON CONFIDENTIAL PROFESSIONAL PRACTICE:

SAFENET members practice **total confidentiality** for the safety and protection of survivors/victims. Privacy must be ensured during interviews and support. Each agency will treat survivor assessment information confidentially within their agency and throughout the referral process. Information will be shared on a 'Need to Know Basis' and will only be shared with individuals and/or organizations providing assistance, or as requested and agreed by the survivor/victim. General SGBV incident data that is shared between agencies and/or used to understand prevalence and response will be non-identifying. All written information will be kept in secure, locked locations.

Total confidentiality does not apply if there is an overriding public interest, for example, a serious imminent risk to the life and safety of a person. The FPA requires that confidentiality be broken when the patient is under the age of 18 years old and if a health worker suspects that the child is a victim of child abuse. The health worker must report suspected child abuse to the social welfare division or the police and consent is not required. Reporting is not mandatory for adult survivors (18 years and above).

Confidentiality and Information Sharing Protocol (CISP)

CONFIDENTIALITY PURPOSE:

The SAFENET CISP aligns the SOPs with the RSIPF (CO/2016/NO/003), the CWA, and the MoH NCPG (2016). Total confidentiality promotes safety and trust. It means that information about the victim/survivor case will be kept secure and only shared with individuals and/or organizations providing assistance, this includes family members. Permission is needed to share victim/survivor information.

Section 11.5 Support and Assistance for Victims

11.5.4 the RSIPF's shall respect the privacy of offenders and victims, and not make idle gossip about individuals involved in family violence cases

RISPF COFV (CO/2016/NO/003)

Clause 19 of the CWA re: Protection of person reporting states 'where a person makes a report or discloses information concerning a child under this act in good faith, the report or disclosure does not constitute a breach of professional advocates or ethics or departure from accepted standards of professional conduct;.

In other words it overrides obligations of secrecy and non-disclosure on the part of professional.

Part 5 of the Act outlines general offenses including 56 which 'makes it an offense for a person to publicize the identity of a child who is subject to care and protection proceedings'.

The MoH NCPG (2016) identify 'guidance on safe, confidential and consented referral of survivors between multi-sectoral services for survivors of SGBV as a key objective (1.2 page 9).

Privacy, confidentiality and informed consent as a guiding principle. 'All patients who present to MHMS facilities who have suffered either physical or sexual assault are to be treated in a private area that is separated from other patients and allows for confidential communication. The 'spouse (husband or wife) or other family members should not be present during examinations/treatments until informed consent is given and the survivor specifically requests the presence of a supportive person of their choosing' (page 15).

3.2 Policy minimum standards on reporting (external and internal)

'it is essential that all SGP cases are documented in a confidential way that does not put the survivor at further risk.

Recording finding/treatment and health record books may put the survivor at risk and often the survivor cannot keep these books confidential (pages 18-19).

clinic or hospital registers should not reflect the cause of injury (e.g. rape, abuse etc.) if there are concerns that confidentiality might be at risk (page 19).

Electronic records should only be accessed on a 'need to know' basis by those providing treatment and follow-up. Flagging medical charts as a 'rape case' or a 'domestic violence' case should be avoided. (Page 19)

a. Internal reporting within the health system

documentation should be kept in a safe/secure and locked filing space. Should be accessible only to authorized staff involved in the survivor's treatment (page 19).

The practice of *Total Confidentiality* reflects the belief that victim/survivors have the right to choose who they tell their story to. Breaching confidentiality can put the victim/survivor and others at risk of further harm. Breaches in confidentiality can also discourage others from coming forward for help. Total confidentiality helps to prevent the malicious use of a survivor/victims' information and/or a misinterpretation or distortion of facts.

Table 20: Confidentiality and Information Sharing Process

	SAFENET Direct Service Provider	SAFENET Case Manager
1.	Find a private setting to conduct the interview (as per Referral Pathway)	
2.	As part of the informed consent process explain and discuss confidentiality and its limitations, • the type(s) of information to be collected • who will have access to it, • how it will be used, • how it will be stored • the types of information you may have to share with another agency providing services • clarify which organisations can and cannot be given the information • explain identifying and non-identifying information	

	SAFENET Direct Service Provider	SAFENET Case Manager
3.	Explain 3 exceptions to confidentiality 1. If the survivor/victim is at risk of harming herself. 2. If the survivor/victim is at risk of harming another person (possibly homicidal) 3. If the survivor/victim is in very serious and immediate danger	
4.	Explain victim/survivor has the right to place limits on the type(s) of information to be shared i.e. what information they want to keep confidential or want to share.	
5.	Obtain consent to gather information (as per Minimum Standard #4)	
6.	Decide what information will be shared and explain how his/her information will be shared and stored amongst other agencies	
7.	Obtain consent to share information (as per Minimum Standard #4 and use Permission to Share / Exchange information Form Annex 13)	

Protocol:

- Interview will be conducted in private settings
- Information will only be shared internally and externally on a 'Need to Know Basis' and only with individuals and/or organizations providing assistance
- People assisting with SGBV cases cannot discuss any case information with family, friends or co-workers who are not involved with the case
- SAFENET members will distinguish between identifying and non-identifying data being collected
- All written information with identifying details will be kept in locked / secure space such as filing cabinets.
- Only non-identifying data will be shared in the referral form and in SAFENET reports. The exceptions are case management meetings when identifying information may be used, but only with the consent of the victim/ survivor
- Service providers / case managers must explain to survivors how information will be shared and stored in your agency and in each of agency being referred to
- If any reports or statistics are to be made public, or used in SAFENET monthly meetings only one responsible officer in the organization will have the authority to release such information and any identifying information about the violent situation (e.g. name, address, telephone) will be removed
- Participants in case management meetings must be invited; it is not a regular open meeting for SAFENET members.

Exceptions to Confidentiality

1. If the survivor/victim is at risk of harming herself.
2. If the survivor/victim is at risk of harming another person (possibly homicidal)
3. If the survivor/victim is in very serious and immediate danger

Permission to share/exchange information form

Any discussion outside the FSC about the client needs the client's permission. The client has the right to share her story with anyone, but the case manager must get permission. The client may only want specific things shared and may want to keep some things private. It is her right.

4. MINIMUM STANDARD ON INFORMED CONSENT

All SAFENET members will obtain informed consent from victim/survivors before treatment/ delivery of service. Victims/survivors will be informed of all options including the risks and benefits of choosing each option and of the right to decline services. Survivors/victims' permission will be sought to provide services, collect and store data and to be referred.

The SAFENET *Informed Consent* requirement aligns the SOPs with the RSIPF CO/2016/NO/003 and the MoH NCPG (2016).

Section 11.2.6 stipulates the responding officers shall ensure the victim is informed of the following:

- the judicial process and victims rights
- process for obtaining a protection order
- community resources and local family violence support services

Section 11.3.6 states 'Section 13 of the FPA states police officers must get a copy of the PSN to the affected person, personally serve the PSN on the respondent and complete and file an affidavit of service with the court. Officers must explain to the respondent the PSN notice and consequences of breaching the notice.

RISPF COFV (CO/2016/NO/003)

The MoH NCPG require:

3.2 Policy minimum standards on reporting (external and internal)

- health workers must ensure that survivors (or their guardian) understand when, how and why they are documenting their story and injuries, and how this information will be stored and used. Informed consent should be obtained for each stage of the medical process (page 19).

b) External reporting to the police/legal system

- health workers should 'offer to report and support the survivor in discussing and deciding on options. The choice whether to report the violence must remain with the adult survivor' (page 21).
- health workers must explain 'any limits of confidentiality to the child survivor have a consenting adult at the beginning of a visit' (page 21).

3.3.3 medical interview, history taking and medical exam

- obtain informed consent before every step of the physical examination / before you do anything (page 24) .

3.3.5 clinical care for sexual violence

- 'use shared decision-making with the survivor, to determine whether HIV PEP is appropriate (page 26).

3.3.7 additional information on child survivors of violence

- Informed consent and assent: a parent or legal guardian should give informed consent for examination of the child, unless he or she is the suspected perpetrator. In this case, a representative from the police, social welfare/ protection worker, the community support services or the Court may sign the form. Adolescent minors may be able to give consent themselves.

Informed Consent Purpose

Informed consent is the voluntary agreement of an individual who has the legal capacity to give consent. To provide informed consent the individual must have the capacity and maturity to know about and understand the services being offered and be legally able to give their consent (MoH NCPG 2016).

The survivor/victim has the freedom to choose whether to seek assistance, what type(s) of assistance and from which organisations. Victim/survivors have the right to:

- stop the interview at any time,
- refuse to answer,
- ask questions and share concerns,
- privacy and to know the exceptions to it,
- informed consent,
- clear and honest information about the services,
- place limitations on the type(s) of information to be shared, and
- specify which organisations can and cannot be given the information

Informed consent is needed

1. To provide direct services
2. To collect and store data / information
3. At the start of case management services (Option 1 in Referral Pathway)
4. To refer to other services providers (Option 2 in Referral Pathway)
5. To share information.

Table 21: Informed Consent in Referral Pathway

Immediate Response Action used by all SAFENET Entry Points					
Private Room to talk Safe/Caring environment	Informed Consent	First-line crisis support Psychological First Aid	Medical First Aid and **if less than 3 to 5 days since rape incident, access Essential Medicine quickly	**Mandatory 3 Risk Assessment** **Questions** Yes Response Flags High Risk Case and Mandatory Basic Safety Planning	Offering Referral Options: 1. Case Management or 2. Direct Referral to SafeNet partners for service **fill out SAFENET referral form

INFORMED CONSENT PROCESS

To ensure consent is "informed", service providers must do the following with the victim/survivor:

Table 22: Informed Consent Process

	SAFENET Direct Service Provider	SAFENET Case Manager
1.	Provide her with honest and complete information about the service available at point of entry/ SAFENET and options available through case management support or SAFENET referral so that she can make choices	
Note: All SAFENET members must be clear about the services provided by other agencies to whom they refer a survivor/victim and the processes involved		
2.	Clearly explain what cannot be provided or any limitations to the direct service / your role as a case manager to support victim/survivor to avoid creating false expectations. i.e. case managers role to get the help needed to live life free from violence and the purpose of case management to avoid creating false expectations	
3.	Explain what will happen to her in the service being providing and/or referral process and/or case management support and ensure that she understands;	
4.	Explain the benefits and risks of the service you are providing / case management support / SAFENET services and sharing information about her situation and ensure that she understands;	
5.	Explain that it the victim/survivor requests support her consent is needed for the provision of services and for referral; (see Annex 14 Sample Wording for Informed Consent Process)	
6.	Inform her that she may need to share her information with others who can provide additional services and obtain her consent; (see Annex 13)	
Note: The survivor/victim must also understand and consent to the sharing of non-identifying data about her case for data collection and security monitoring purposes		
7.	Explain she has the right to decline or refuse any part of services, and the right to place limitations on the type(s) of information to be shared, ensure that she understands;	
8.	Explain and discuss confidentiality and its limitations on the type(s) of information to be shared, and to specify which organisations can and cannot be given the information and ensure that she understands the implications	
9.	Decide what information will be shared and explain how his/her information will be shared and stored amongst other agencies.	
10.	Have client sign SAFENET client consent form (see Annex 15)	

	SAFENET Direct Service Provider	SAFENET Case Manager

There is NO CONSENT when:

- Agreement is obtained through the use of threats, force or other forms of coercion, abduction, fraud, deception or misinterpretation;
- There is a threat to withhold a benefit or a promise to provide a benefit is used; and,
- When a person is below the legal age of consent (18) or is defined as a child under the law.
- **Note:** MoH National Clinical Practice Guidelines (2016) provide details of Informed Consent and Assent Guidelines for children.

INFORMED CONSENT GUIDANCE NOTES:

What to do if the victim/survivor does not want to be referred?
It is important for case managers to remember that many victim/survivors will not want to be referred to a safe house, the police, or for legal or medical counselling. Case managers need to be prepared to discuss all of the options available to the victim/survivor in detail so that she is able to make an informed decision. If she chooses not to be referred respect her decision but make sure to discuss the risks associated with her decision i.e. of possible escalating violence. Our instinct may be to want her to go to a shelter to get away from the abuse, to the police or legal officers for legal advise or an IPO, but we have to put this aside and be guided by the victim/survivor.

5. MINIMUM STANDARD ON ACCOMPANIMENT AND FOLLOW-UP (CASE MANAGEMENT):

SAFENET will offer **case management support** to victims/survivors. The service recognizes the value of someone to guide, support, accompany, follow-up and track victim/survivors through the system until their case is closed. It is a collaborative process between the case manager and victim/survivor to assess, plan, facilitate and advocate for options and services to meet a victim/ survivor's immediate and secondary needs. It is a process of support that links victims/ survivors to available resources through communication and information sharing. Case management encompasses any type of intervention that helps a victim/ survivor to access and maintain access to the SAFENET SGBV assistance needed from the point of entry and as they move from one point of entry to another until the case is closed. It uses a strengths based approach to identify and acknowledge the victim/survivor's strengths and to plan around and build on them through the process toward recovery. The type of intervention depends on and is shaped around the needs of each victim/survivor (see case management pathway page 51).

SAFENET CASE MANAGEMENT SERVICE PURPOSE:

The overall aim of the SAFENET case management service is to assist victims/survivors to access the appropriate SGBV services and make their way through services provided by multiple agencies though a coordinated referral process. In so doing, the service will provide a continuity of care for victim/survivor from entry point to case closure. Its purpose is fourfold: to reduce barriers to SGBV support and care; to prevent victims/ survivors from dropping out or falling through the cracks of service provision by multiple agencies; to increase safety in the response system by assessing risk, prioritizing response for high-risk cases and strengthening safety and action planning; and to bring more cases to closure

CASE MANAGEMENT SERVICE:

The case management service will provide demand driven services for victims/ survivors who (as per SAFENET referral pathway in Table 23):

i) self refer / walk in to FSC;

ii) request case management support in the SAFENET 6 step immediate response pathway; or

iii) are referred from any other external source i.e. other SGBV service providers in Honiara or the provinces.

Table 23: SAFENET Immediate Response Actions

Immediate Response Action used by all SAFENET Entry Points					
Private Room to talk Safe/Caring environment	Informed Consent	First-line crisis support Psychological First Aid	Medical First Aid and **if less than 3 to 5 days since rape incident, access Essential Medicine quickly	**Mandatory 3 Risk Assessment Questions** Yes Response Flags **High Risk Case** and Mandatory Basic Safety Planning	Offering Referral Options: 1. Case Management or 2. Direct Referral to SAFENET partners for service ** fill out SAFENET referral form

Case managers do not replace other SAFENET services, rather they work with SAFENET services providers to provide more in-depth support to victims/ survivors that other agencies are unable to meet due to resource constraints and case overload. All victims/survivors reporting to a SAFENET service provider will be advised of and given the choice to access case management services as a part of the six-step immediate response pathway (see SAFENET referral pathway). Case management services, like all other SAFENET services require the consent of the victim/survivor.

Case managers are responsible for implementing the seven core functions of case management (see Case Management Process page 48):

- Introduction - Engagement and relationship building
- Intake and assessment - information collection and assessment (including risk assessment);
- Case action plan - planning and prioritisation of needs (including safety planning);
- Implementation of action plan - direct service and/or referral
- Case follow-up of the action/safety - have clients goals been achieved plan/ review /reassess / revise plan; and
- Case closure
- Evaluate service provision[2].

2 Case management materials draw heavily on the International Rescue Committee (IRC) GBV Emergency Response & Preparedness: Participant Handbook and Survivor-Centered Case Management Training Guide

In summary a Case Manager:

- Is a friendly person who can develop a trusting relationship that helps the victim/survivor;
- Supports and advocates on behalf of the victim/ survivor;
- Acts as the survivor's Point-of-Contact in SAFENET for assessment of need;
- Identifies services needed and develops goals with the victim/survivor;
- Provides coordination and follow-up on provision of services;
- Organizes case review meetings and case conferences

One case manager will be assigned to each victim/survivor and will become the primary point of contact for victims/survivors who choose case management support. They will make referrals to and receive referrals from the referral SAFENET in line with the SAFENET referral pathway. Survivor centered case management requires that the case manager use the assessment process to help the survivor to identify her strengths and assets to achieve her goals.

Case managers may or may not be the first to assist the victim/survivor to assess and identify her needs and goals depending upon whether she self-refers or is referred. Her referral pathway will determine where the assessment begins and ends. If referred the case manager will need to engage with her and build a trusting relationship. To avoid duplication of information collection and assessment, when cases are referred a case review meeting will take place involving the victim/survivor, case manager and intake officer from the referred SAFENET member agency.

Internal recording of SGBV Information by case managers at Intake

Case managers will use the template Client File (Annex 16) for the intake assessment process. All client files are assigned a client number to enable onward use of non-identifying data (with the client's consent).

- Active Client files are kept in a locked cabinet. They are only accessible to the assigned case manager and authorized staff involved in the victims/ survivors' case.
- The Client File should never leave the office.
- Onward use of client information requires the clients' consent and must be non-identifying. It will use only a client number to identify the case
- The counselors and lawyer in FSC will keep separate files for the work they do.

The **Client File** is the form used for all clients who have given Informed Consent to Participate in Case Management Services. The Client File is made up of five parts:

1. Information about the client's social situation (family, income, marital status, etc.)
2. The story about what happened to her and why she is seeking help.
3. Assessment of risk/danger (to self, others or towards the client)
4. Empowerment Counseling: explaining the client's Rights and Options
5. Developing an Action Plan with the client. The Action Plan is a living document that is reviewed and updated regularly until the file is closed.

The assessment may take a couple meetings if the client is in pain, exhausted, or needs immediate medical care.

The assessment can be completed as the client tells her story rather than asking many questions. It is a tool to assist the client rather than something that is mandatory to complete. If a part is not helpful, leave it blank.

Case Session Notes are attached to the file (see Annex 16 end). Every contact with the client is documented. It could be a phone contact, a review of the Action Plan, a visit at CCC or accompaniment. There are four case notes per page and the case manager can take these in the field with them since the client's name is not on it, only her number. These sessions will be counted when the file is closed to indicate: number of sessions and number of times accompanied. The closing information is documented on the last page of the Client File and on the Data Summary Sheet.

Weekly Workplan (see Annex 17). This is a weekly plan for scheduling clients and keeping track of how many new clients and sessions were held that week. This is turned in weekly to the supervisor who needs to help the team distribute the work load evenly. The goal is for each case manager to average 4 to 6 contacts/sessions a day.

If a client is a "no show" to a scheduled appointment, the case manager calls immediately to make sure the client is safe and if there is a need to revise the Action Plan

SAFENET: Case Management Process

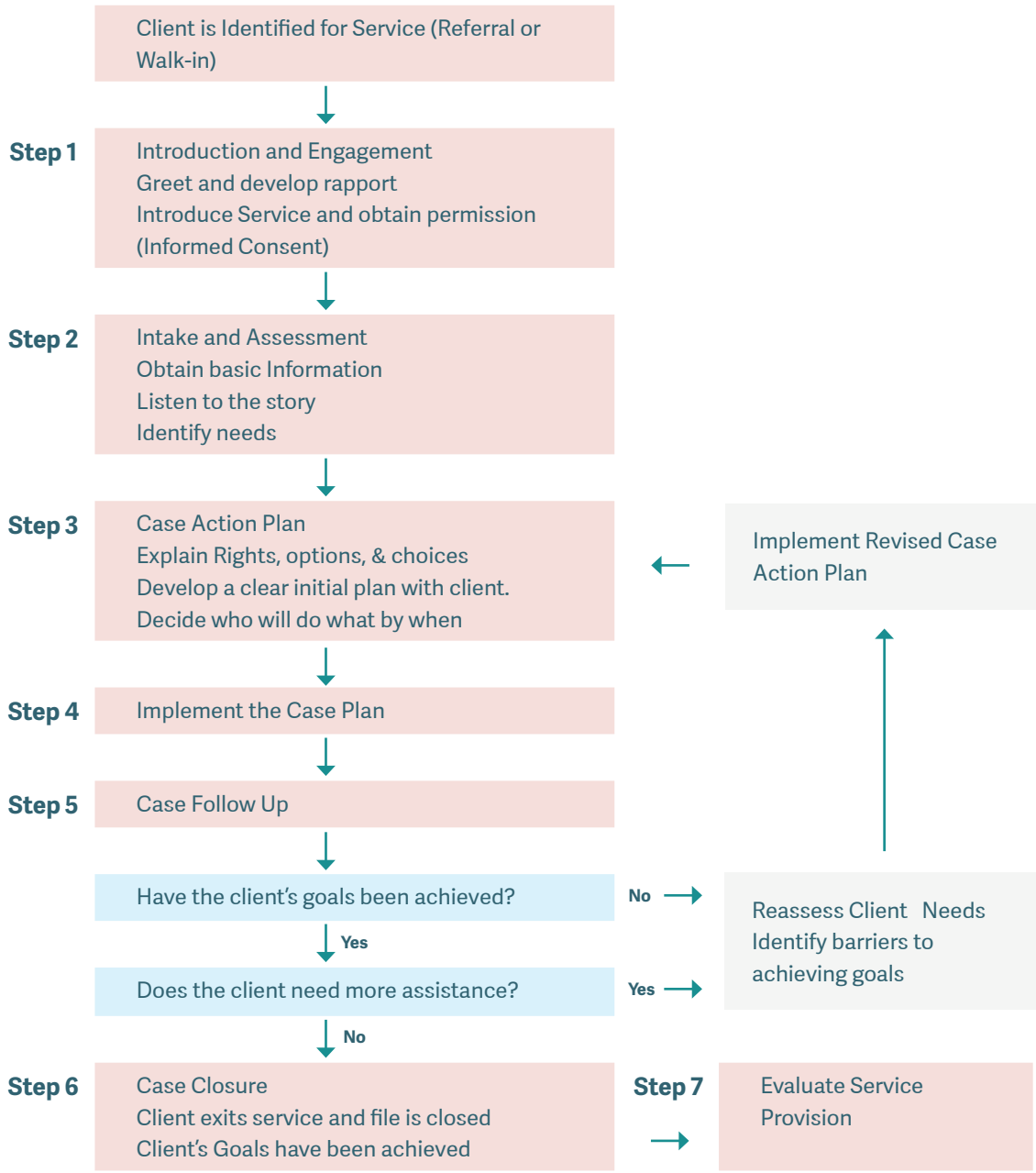


Chart adapted from: ICRC, CCC Guide, 2010

CASE CONFERENCE

Case conference will be scheduled as and when they are needed with SAFENET service providers to discuss complicated and high-risk cases of SGBV; cases that are not straight-forward and require more than one agency to meet the needs of and provide support for the survivor. Initially only high risk and complex cases will be prioritized.

The **overall purpose** of the case conference is to enable the case manager and/or SAFENET service provider to bring cases they are concerned about and/or unable to handle alone, to a group of service providers for discussion and planning. The primary focus is to safeguard the survivor and her/his children and manage perpetrator behavior by linking with other agencies.

The **specific objective(s)** of the case conference meeting will be:

- To discuss risks faced by survivors in each case of high risk SGBV / DV identified within SAFENET;
- To share information and discuss the actions needed to ensure the safety and well-being of the survivor and to improve support for staff involved in complex cases;
- To determine if the perpetrator poses a risk to any particular individual, the general community or service providers;
- To work together to develop and implement a safety and/or action plan that provides support including to those at risk;
- To identify or clarify ongoing issues regarding the survivor's case;
- To advocate for services in a timely manner within legal and criminal justice systems and social service agencies; and,
- To ensure the resources available locally are shared and used to create a safety/action plan involving all the necessary agencies.

The **kinds of cases** that might be referred to a case conference meeting include:

- repeat acts of violence within the family toward a woman and her children;
- safety concerns about the survivor e.g. the husband has threatened to kill her and/or has weapons in the house; threats of self-harm /suicide;
- the victim/survivor has suffered serious trauma / harm from violence (physical, sexual, psychological);
- Police Safety Notices and/or Protection Orders are not working or have been breached;
- serious cases that have no solution after trying other interventions; and,
- very aggressive perpetrators.

The **case manager's role in a case conference** is to:

- advise the team leader of the need for a case conference;
- support the specific objectives of the case conference;
- lead the case conference on behalf of or with the survivor;
- support the survivor (emotional, accompaniment, referral);
- provide information about the strengths of the survivor which can be used in safety and action planning;

- debunk misinformation that might come up in the meeting regarding domestic violence;
- provide follow-up support to the survivor
  - What was most helpful about the case conference?
  - What worried you the most are made you most uncomfortable?
  - What has happened since the meeting to improve your situation? To worsen it?
  - Was the plan that was developed at the conference it into place?
  - Would you recommend another case conference, why or why not?

Information to bring to case conferences:

- Biographical data (survivor/perpetrator)
- Case history
- Current issues / what is going on now
- Action / safety plan
- Action taken (services)
- Actions required
- Responsibilities of service providers
- Follow up taken so far and blockages/issues in the response

Preparation for the case conference with the survivor

- Are there any specific topics to avoid?
- Does the woman have safety concerns about anyone else who may be attending the meeting?
- Does she want to discuss her case at the case conference?
- Does she feel that she can safely speak about her case or does she want the case manager to speak?
- What does she fear could go wrong with the case conference? What would be the consequence?

The **role of the SAFENET Case Conference Meeting Members** is:

- Crisis intervention;
- Information sharing and risk management;
- Safety and action planning;
- Arranging transportation;
- Ensuring accompaniment support of survivor to the police, court and other appointments as required;
- Emotional support;
- Information and referral to other community resources as required; and
- Advocacy within legal and criminal justice systems and social service agencies

Core Group - SAFENET members

- Social Welfare Division
- Ministry of Health and Medical Services (MHMS)
- Integrated Mental Health Services
- National Referral Hospital (NRH)
- Public Solicitor's Office - Family Protection Unit
- Royal Solomon Islands Police Force (RSIPF)
- Family Support Centre (FSC)
- Christian Care Centre (CCC)

Other non-SAFENET members
Other SGBV service providers may be invited to attend a meeting if they have particular knowledge of a case or they have a specific service that will help to support a woman and her children. These representatives will be invited to attend meetings on an 'as needed' basis to inform the assessment, including risk assessment or the management of the plan including the safety planning.

Frequency of Case Conference
Case conferences will be called on an as needed basis. The case manager team leader will call conferences for high-risk or complex cases that require immediate attention. SAFENET member organizations, in consultation with the SAFENET coordinator and the case management team leader at FSC can also call a case conference.

Location(s) of Case Conference
There are three different options for the location of case conferences:

1. At FSC in a secure and confidential office;
2. By telephone: a) if the case conference involves only two agencies and the parties agree to discuss the case on the telephone and can ensure that confidentiality is maintained, b) if the case conference involves two or more parties and a three way telephone conference call is possible and the parties can ensure that confidentiality is maintained
3. In an agreed secure and confidential location

6. MINIMUM STANDARD ON SKILLS AND TRAINING TO STANDARDIZE SAFENET RESPONSE AND REFERRAL:

SAFENET **training and orientation workshops will be implemented regularly** (annually) to ensure members are up to date on and able to implement the Minimum Standards for referral and coordination. Training will be in line with established competencies .

SAFENET Competencies
SAFENET aims to standardize the response and referral process of members using a planned capacity development program to enhance skills building and the transfer of knowledge and skills to the referral SAFENET participants. Competency ladders have been developed with 5 tiers (see Table 24) and reflect the roles and responsibilities of SAFENET frontline service providers and case managers in the referral and coordination of SGBV services for survivors. Training modules are shaped around core competencies to implement the 10 Minimum Standards. They align with core competencies for the SAFENET case manager (see Table 25).

The identified competencies should inform all training so it develops core skills:

- The gender and human rights based dimensions of violence;
- The prevalence, causes and impacts of gender-based violence in the Solomon Islands;
- The policy and legal frameworks related to gender-based violence in the Solomon Islands
- How to implement and survivor centered - strength based approach;
- How to provide first support, including psychological first-aid and effective communication skills;
- How to obtain informed consent and explain survivor rights,
- How to implement privacy and confidentiality protocols;
- How to undertake intake and risk assessments;
- How to do safety and action planning;
- How to refer onwards and provide safe accompaniments support;
- Public prevention messaging in line with zero tolerance for SGBV

Competency is the ability to do something well as measured against a defined standard.

A **core competency** is the ability to perform a specific set of skills that will best meet the needs of the victim/survivor. It is a distinct area of knowledge. Core competencies serve as building blocks to respond to SGBV

Knowledge is a body of information that applies directly to the performance of a function required on the job. Knowledge can come from books or classes or from something we pick up along the way.

Core competencies for SAFENET service providers in referral and coordination:

1. Understanding sexual and gender-based violence in the Solomon Islands and the physical, psychosocial and socio-economic consequences;
2. Understanding and application of the 10 minimum professional standards for referral and coordination of SGBV services for survivors;
3. Understanding how to implement a survivor centred approach;
   a. Knowledge of survivor rights (Constitution of Solomon Islands, FPA, EVAWG, GEWD, CWA)
   b. Knowledge of how to assist survivors to identify and express their needs re: referral pathway
   c. Knowledge of how to assist survivors to choose a course of action in referral pathway
   d. Knowledge of how to support survivors to take decisions about the course of action
4. Informed consent;
5. Confidentiality and information sharing;
6. First-line support and psychological first aid;
7. Identification of high-risk cases (as per the SAFENET referral pathway);
8. Basic risk assessment and safety planning;
9. Facilitating decision making and planning with survivors;
10. Full range of SGBV services and procedures of SAFENET partners;
    a. RSIPF procedures for issuing police safety notices and protection orders
    b. PSO roles and responsibilities in line with the Family Protection Act
    c. CCC services, procedures and regulations for temporary safe housing and pastoral counselling
    d. FSC services (counselling, legal and case management)
    e. Ministry of Health (procedures for emergency and medical treatment of SGBV cases)
    f. Social Welfare Division roles and responsibilities in line with the Child Welfare Act;
11. How case management services function (referral, intake, accompaniment and follow-up procedures);
12. Effective safe referral (as per SAFENET referral pathway and SAFENET referral form)
13. Conducting the intake interview (in line with sector requirements and as per SAFENET referral pathway) with adults and transferring information from intake form to non-identifying referral form
14. Conducting the intake interview (in-line sector requirements and as per SAFENET referral pathway) with children and adolescents and transferring information from intake form to non-identifying referral form
15. Prevention and advocacy messages in line with zero tolerance for SGBV and FPA service provision

SAFENET CASE MANAGERS

Case managers have a combination of counselling and advocacy skills. Their role is as cousnellor and advocate. As a counsellor the case manager seeks to help the survivor learn to cope with their trauma through awareness, acceptance and understanding of their reactions. They seek to provide a sense of safety and security for the survivor. The counselor provides a non-judgmental environment for the survivor

to examine their options. A counselor is supportive and unthreatening to survivors. The case manager as an advocate helps to bring about outcomes. They ensure that the survivor is treated with sensitivity and respect, and assists with necessary communication between the survivor and organizations/ agencies including hospitals, mental health professionals, child protective services, law enforcement, Public solicitors offices and courts.. The advocate assists a survivor's decision-making. Following an assault, the survivor is faced with a number of decisions that must be made. The advocate provides information necessary for those decisions to be made and then provides support while the survivor tries to put those decisions into place. The Case manager advocate helps a survivor stand up for their rights and to the extent possible, ensures that these rights are respected.

Table 24: SAFENET Referral and Coordination Competencie

LEVEL	Skill Competence SAFENET Partners
Level 1	Awareness and learning demonstrated through participation in training, discussion, and note-taking.
Level 2	Demonstrate knowledge and application of skill in written exercises.
Level 3	Demonstrate skill in role play exercises.
Level 4	Demonstrate skill while working with clients/patients.
Level 5	Demonstrate ability to teach others the skill.

Ethics Foundational	Attitude	Skills/Behavioral Anchors	LEVEL Rating	Knowledge
SAFENET Minimum Standards	• Commitment to integration of referral and coordination standards & knowledge into professional practice • Open-minded, curious • Willing to learn • Awareness of own limitations and the challenges of SGBV interventions.	• Define and discuss key Minimum Standards • Can articulate own identity with unique values, assumptions and biases. • Identifies ethical dilemmas that arise in daily work and uses standards as guides for ethical-decision making. • Engage in practice guided by Minimum Standards **Trauma work:** • Aware of different interests when working with families on issues related to violence and child protection. • Avoids role conflicts and multiple relationships.		• Knowledge of SAFENET competencies • Knowledge of SAFENET Minimum Standards & Survivor Centered Approach • Awareness of interaction between legal issues and Minimum Standards.

Ethics Foundational	Attitude	Skills/Behavioral Anchors	LEVEL Rating	Knowledge
Professionalism	• Honesty • Integrity • Takes personal responsibility • Committed to professional values • Shows concern for the welfare of others.	• Demonstrates awareness of how behavior impacts clients, community, and profession. • Attendance at work, meetings, and client sessions is timely and reliable. • Makes sure that survivor care is prioritized when there is an absence or schedule conflict. • Documents activities in a timely and accurate manner. • Acknowledges and is able to discuss lapses in adherence to professional values with supervisor.		• Knowledge of organizational skills

Ethics Foundational	Attitude	Skills/Behavioral Anchors	LEVEL Rating	Knowledge
Reflective Practice	Mindfulness, self-awareness, self-monitoring Reflection on action Intellectual curiosity and flexibility Interested in lifelong learning	• Is aware of one's level of competency and sets goals to increase competency. • Is aware of self, personal attitudes, beliefs & biases and culture and how they impact survivors of sexual assault and family violence and professional practice • Is aware of self, professional role and community • Uses SAFENET meetings to enhance reflection and review of own and agency performance in a transparent manner. • Trauma work: • Has tolerance for intense affect and content. • Shows awareness of how personal history impacts work.		• Knowledge of Respectful Model • Knowledge of personal strengths and style

Competencies Functional	Attitude	Skills/Behavioral Anchors	LEVEL Rating	Knowledge
Communication Building Rapport	• Warm, patient, empathetic, compassionate, genuine, non-judgmental • Belief in resilience and strength of survivors; • Belief in dignity, respect and for survivors	• Attending Skills: • Visual/eye contact • Vocal qualities • Verbal tracking: follows survivors topics • Body Language • Demonstrate ability to increase survivor talk-time while reducing own talk time. • Is aware of the SAFENET referral pathway for immediate response • How to create space for private disclosure • How to create individual comfort • How to ask (in open ended ways) • How to allow for disclosure to happen at survivors pace Trauma work: • Ability to attend to trauma-related material with respect and dignity demonstrating a belief in recovery/resilience. • Sensitive and appropriate response to disclosure • Understands how trauma impacts first responders		• Local culture • Trauma informed services • Survivor centred communication styles

Competencies Functional	Attitude	Skills/Behavioral Anchors	LEVEL Rating	Knowledge
First Line Crisis Support / Basic Counseling Skills	• Believes the survivor has the ability to find her own solutions and make her own decisions about what is best for her and her family. • Acknowledges that the survivor is the expert for her own life.	• Follows the survivor's lead • Avoids giving advice • Adapts to the style of the survivor using the following skills: • Open and Closed Questions • Observation • Encouraging • Paraphrasing • Summarizing • Reflection of feeling		Theory: Person-centered listening skills Knowledge of the effects of trauma on survivors
Psychological First Aid (PFA)	Calm, nonintrusive stabilizing support in the immediate aftermath of a traumatic/crisis event	- Demonstrate the 8 Core Actions with adults Contact and Engagement Safety and Comfort Stabilization (if needed) Information Gathering: current needs/concerns Practical Assistance Connection with Social Supports Information on Coping Linkage with collaborative services - Demonstrate the 8 Core Actions with children and families		WHO guidelines Knowledge of positive coping mechanisms used in culture.

Survivor Centered Referral and Coordination	Attitude	Skills/Behavioral Anchors	LEVEL Rating	Knowledge
Empowerment Counseling	Helpful, non-judgmental, informative, patient No hierarchy of victimization Believes the survivor has the ability to find her own solutions and make her own decisions about what is best for her and her family. Acknowledges that the survivor is the expert for her own life.	Ability to explain to a survivor her Rights under the SI Constitution and the Family Protection Act (FPA). Provide information about the "Cycle -of-Violence" to assist the survivor to recognize danger and enhance protection skills. Ability to provide information regarding options and community resources to enhance the Survivor's choice-making and problem-solving. Ability to promote survivor recovery by taking action to gain control over her life, rather than leaving her feeling powerless		Knowledge of survivor Rights under SI Constitution, FPA, referral pathways, key stakeholders. sexual violence, causes, Cycle of Violence, dynamics of Power/Control
Informed Consent	Open, friendly, no pressure Belief that the survivor has the right to choose what will happen to them.	Clearly explain services being offered so that the survivor can make a choice: goal of service, process of case management, confidentiality, potential risk/benefits, choices to stop, continue, change plan.		Knowledge of survivor-centered services, SAFENET Minimum Standards

Survivor Centered Referral and Coordination	Attitude	Skills/Behavioral Anchors	LEVEL Rating	Knowledge
Intake Assessment	Collect information while building/ maintaining rapport Non-judgmental, open and compassionate Confidence even when speaking of sensitive family issues.	Ability to facilitate survivor centred individualized assessment (as per organization forms), including Complete demographics and relevant history Identify survivor's strengths and say them to the survivor. Identifies social/family situations that impact recovery Identifies and assesses past experience of violence Identify/Assess risk of harm: suicide, self-harm, danger to others, continuing danger towards survivor or survivor's children. Identify needs: legal/justice, health care, psychosocial, safety, shelter. Memorize forms so that minimal attention is needed to the paperwork while obtaining complete information.		Knowledge of Strength-based assessment

Survivor Centered Referral and Coordination	Attitude	Skills/Behavioral Anchors	LEVEL Rating	Knowledge
Risk Assessment (Mandatory and intake risk assessments)	Collect information while building/ maintaining rapport Non-judgmental and compassionate Confidence even when speaking of sensitive family issues.	Understanding of lethality issues Memorize forms so that minimal attention is needed to the paperwork while obtaining complete information. Identify/Assess risk of harm: immediate and continuing danger towards survivor or survivor's children or service providers; safety in the home Determine risk category / Identify high risk cases		Knowledge of safety issues related to SGBV, Safety Protocol, Risk assessment tool and how to use it
Basic Safety Plan	Non-judgmental and compassionate Belief that the survivor has a right to choose what will happen to them Confidence even when speaking of sensitive family issues.	Use of risk factors identified in risk assessment specific to each survivor and her children to plan Understands relationship between risk assessment and safety planning Develop an Action Plan for Safety Review and modify Safety Action Plan at each contact Ability to develop a plan with survivors who cannot read		Knowledge of safety issues related to SGBV, Safety Protocol, Risk assessment tool and how to use it, safety planning

Survivor Centered Referral and Coordination	Attitude	Skills/Behavioral Anchors	LEVEL Rating	Knowledge
Basic Action Plan	Collaborative Need and goal-oriented Belief that the survivor has a right to choose what will happen to them Belief that the survivor is the expert for her own life.	Identify survivor's goal and establish priorities: health care, access to justice, psychosocial support, other Together with survivor, identify steps that will be taken to support survivor and steps the client will need to take to reach goals (who does what and when) Agree on frequency of contact Ability to involve survivors in their own planning process by helping them to understand options and exercise self termination Ability to identify assets and needs (e.g. transportation, etc.) Ability to reinforce survivors capacity to take decisions		Knowledge of Strength-based action planning

Survivor Centered Referral and Coordination	Attitude	Skills/Behavioral Anchors	LEVEL Rating	Knowledge
Referral	Collaborative Confident Assertive Belief in right of survivor to access range of service Belief in accountability of SAFENET service providers	Ability to identify a range of community resources (people, places, things and money) that can assist survivors Ability to create and manage good working relationships and network with other community agencies and potential partners to facilitate the Survivor's goals. Ability to connect survivors with resources Demonstrate ability to speak with medical, legal and social welfare system in ways that safeguard survivors (safety, choices, and confidentiality) and enhance outcomes. Ability to advocate for timely and safe survivor services Anticipate possible roadblocks in accomplishing their goals and be able to overcome these roadblocks		Knowledge of SAFENET service providers, available services, agency SOPs and roles and responsibilities of each agency, key contacts, FPA, EVAW, CWA, RSIPF PSN and Protection Order processes, CARECOM membership
Prevention & Advocacy	**Attitude**	**Skills/Behavioral Anchors**	**LEVEL Rating**	**Knowledge**

Survivor Centered Referral and Coordination	Attitude	Skills/Behavioral Anchors	LEVEL Rating	Knowledge
Advocacy	Collaborative Belief in gender equality and women's rights Belief in zero tolerance for violence against women and girls Belief in accountability for perpetrators of violence	Construct persuasive messages in line with zero tolerance for violence against women and girls Present persuasive messages and arguments to survivor, service providers, and community Create awareness in communities of the FPA and CWA, that domestic violence is illegal, availability of survivor focused services Challenge cultural practices that are harmful to women and girls		Knowledge of sexual violence, causes, Cycle of Violence, dynamics of Power/Control, how to deal with resistance in a persuasive way, zero tolerance messages, available services, FPA, CWA, RSIPF PSN and Protection Order

Case Management	Attitude	Skills/Behavioral Anchors	LEVEL Rating	Knowledge
Case Conference	Supportive to all service providers. Protective of Survivor's rights and dignity Problem-solving vs. blaming	Identifies cases that are "stuck" or not progressing to keep the survivor safe or reach her goals. Organizes a meeting of all who are involved in the services with the survivor's permission. Establishes ground rules and goals of meeting. Invites the survivor to be present as a silent observer and bring a supportive person. Meet with survivor after to debrief and revise Action Plan based on new information.		Knowledge of SAFENET case conference processes

7. MINIMUM STANDARD ON PERPETRATOR ACCOUNTABILITY:

As part of zero tolerance for VAWG, SAFENET members will hold **perpetrators accountable** for their violence. Ensuring greater perpetrator accountability aligns with the objectives of the FPA which criminalizes domestic violence. Specifically, SAFENET members will advocate that the police (and courts where applicable) issue and enforce police safety notices and protection orders (interim and final). Perpetrator accountability means pursuing the offender and working with SAFENET partners to support prosecution provided this is the choice of the survivor. It requires swift action by the police and courts, and monitoring the implementation of court and police conditions.

8. MINIMUM STANDARD ON ACCOUNTABILITY OF SAFENET RESPONSE AND REFERRAL SERVICES:

CARECOM will use the 10 Minimum Standards as a **framework** to hold service providers **accountable**. The accountability framework with the 10 minimum standards can also be used to assess organizations requesting membership into SAFENET. It acts as a guide in cases of conflict of interest, dual loyalty or wontok, priority shall be given to the protection and well-being of the survivor/victim. The interests of the survivor/victim will take precedent over the interest of the organization or community.

SAFENET ACCOUNTABILITY FRAMEWORK

The Accountability Framework provides the overall architecture for accountability within in the referral SAFENET. The framework is guided by:

- The 4 components of SAFENENT;
  - Direct services and support
  - Referral and Coordination
  - Prevention and Advocacy
  - Governance and Accountability
- The Survivor and Child Centered Approaches; and
- The 10 Minimum Standards for the referral SAFENET

Graphic 8: SAFENET Accountability Framework

The Framework has 4 simple steps:

Step 1: The SAFENET coordinator is responsible for monitoring the implementation of the referral SAFENETs 4 components, the survivor centered approach and the 10 Minimum Standards of practice.

SAFENET will collect, analyse and evaluate evidence regarding response, including the case management service, coordination and referral of SGBV services within the referral network including:

- Provision of direct services from SAFENET partners aligned with the FPA and CWA i.e. issuing of Police Safety Notices and Protection Orders
- alignment with the referral pathway,
- safety issues and use of the safety protocol,
- survivor centered practices of confidentiality, informed consent, case management support and case canferences;
- use of the referral form and non-identifying data;
- coordinated support for perpetrator accountability;
- annual training/ capacity support aligned with SAFENET competencies;
- accessibility of SAFENET services; and,
- coordinated prevention and advocacy programming aligned with zero tolerance position.

The review will be based on performance indicators, agreed benchmarks and national targets for service provision identified in the first annual planning process. It will include:

- processes to capture anonymous information about client/survivor experiences of SAFENET services including case management;
- lessons learned and emerging best practices in Solomon Islands;
- recommendations for changes / additions to the existing system.

This process will be lead by the SAFENET coordinator and will clarify reporting expectations and the associated timeframe bi-annually aligning with the national reporting structure.

Step 2: The results bi-annual review will be shared and discussed collectively with SAFENET members twice a year before being reported to CARECOM and up through the national EVAWG and GEWD structures:

- to the National EVAW Taskforce,
- the GEWD National Stakeholders Taskforce,
- the Advisory Reporting Coordination Committee (ARCC),
- onwards to the MWYCFA, and
- Parliament.

Step 3: Issues and failures to comply with the Minimum Standards of Professional Practice for referral and coordination (and/or breaches in professional ethics such as confidentiality) can be reported to the SAFENET coordinator at any time throughout the year. Reports should be written and will result in:

- An immediate investigation by the SAFENET coordinator (within 10 working days) including the following information
- record the date, times and facts of the incident(s),
- details of any evidence,
- names of witnesses,
- the views of the victim/survivor (if possible) and what outcome s/he wants;
- any formal or informal complaints;
- a letter of notification drafted by the SAFNET Coordinator and approved by CARECOM to be sent to the appropriate SAFENET partner /line Ministry and/or NGO Management
- the appropriate SAFENET partner / line Ministry and/or NGO Management is expected to report back to CARECOM within two weeks indicating how the breach has been and will be addressed outlining any internal Code of Conducts used to guide response procedure.

In the event that the SAFENET coordinator is the subject of a complaint and/or has a conflict of interest investigating the SAFENET partner the CARECOM chair or co-chair will lead the process.

Step 4: CARECOM, through the SAFENET coordinator, is responsible to respond to any response issues identified, specifically failure to comply with the roles and responsibilities of SAFENET partners as per the MOU and the agreed SAFENET protocols.

Specifically, CARECOM and SAFENET partners are obliged to respond to:

- Bi-annual recommendations to change any aspect of the system by the next bi-annual CARECOM meeting;
- Issues and failures to comply with protocols such as breaches in confidentiality, informed consent, safety and professional ethics of practice within two weeks; and
- Outline discussion and agreement on next steps to address any issues

9. MINIMUM STANDARD ON ACCESS TO SGBV SERVICES:

SAFENET members will be guided by a **NON-Discrimination approach**. This means service providers do not discriminate on the basis of sex, gender, religion, age or ethnicity.. All survivors will be treated equally and have all possible options presented to them. No survivor will be discriminated against or blamed. Service providers will strive to support survivors with persons of the same sex, culture and language. Regardless a survivor's history and/or the number of times she has accessed services she will be given the same respect and care as the first time. Service providers will advocate for equal access to justice remedies for survivors and for perpetrators (regardless of community status). In recognition of a survivors/ victims right to quality SGBV services across the country, the Solomon Island Government (SIG) and SAFENET members will work toward making SAFENET a **national network**, available in all 9 provinces and Honiara City Council.

10. MINIMUM STANDARD ON SGBV PREVENTION AND ADVOCACY:

SAFENET members will engage in and/or support **prevention and advocacy** programs to challenge harmful gender norms and facilitate a broader understanding of gender equality and power relations that respect the rights of women and girls. This is in line with the FPA requirement for public awareness programs aimed at preventing domestic violence and the health sector policy minimum standard on advocacy and awareness and prevention in the health sector.

SAFENET members have **ZERO TOLERANCE of VIOLENCE AGAINST WOMEN and GIRLS**, and publicly condemn violence as a violation of a woman's basic human rights. A zero tolerance stance requires that service providers challenge cultural practices that that are harmful to women and girls. SAFENET members will work to develop standard prevention and advocacy messages in line with the zero tolerance position of the network. Members will utilize agreed upon public advocacy messages.

Section V: Data Collection

Non-identifying and timely information about reported SGBV incidents is important for the SAFENET member organizations. This information is needed to maintain awareness of SGBV related response, security, protection and coordination issues in Solomon Islands. It is needed to feed into national reporting processes and monitoring. At the same time, survivors'/victims rights to privacy and confidentiality must be upheld.

The following data is being captured:

1) SAFENET secretariat

The SAFENET secretariat in coordination with FSC will collate non-identifying SGBV referral data through the use of the referral form. This non-identifying data will be stored at a location to be decided by CARECOM.

2) Recording SGBV in the FSC/SAFENET data system FSC Process:

Each client file contains a **Data Summary Sheet** (see Annex 18). This form is completed by the case manager after the initial assessment and is submitted to the **Data Base Administrator**. When the opening data is entered into the computer, the DBA signs the form indicating that it has been entered, and the file is considered officially open. The summary sheet is returned to the case manager to be kept in the file.

If the case manager refers the client to counseling or legal services, this is added to the data summary sheet. The opening and closing dates will be different.

When the file is closed, it is again submitted to the **Data Base Administrator** to close the file in the system.

Data Capture:

Client numbers are recorded in the FSC/SAFENET form by category of:

- Opening file data
  - non identifying client information
  - referred from; referred to
  - type of service
- Closing file data
  - number of review sessions
  - number of times accompanied
  - status client goals
  - type of exit
  - date of closure
- Counselling data
  - opening date
  - closing date
  - total number of sessions
  - functional rating last visit
- Legal service data
  - opening date
  - closing date
  - type of Case
  - closing type total number of consultations
  - total number of court appearances

Data Capture re: case management

- Staff caseload
- Current centre caseload
- survivor gender, age, sex
- referral source
- onward referral
- presenting complaints, type of service
- number of closed files
- achievement of client goals
- type of exit
- Exit status of main presenting complaint

3) National EVAW Indicators being tracked in sector and NGO data collection activities to be used in report to Parliament

- Policy Outcome 1: Violence against women and girls is reduced as a result of holistic prevention strategies
    - Current numbers of awareness workshops by agency and geographical focus: Data source NGOs
- Policy Outcome 2: Legal frameworks, law enforcement and the justice system are strengthened
    - Numbers of protection orders; Numbers of prosecutions under FPA: Data source FPAC committee, Police family violence working group – data sub-committee
- Policy Outcome 3: Victims and survivors have better access to medical, legal and protective services
    - Numbers of women accessing health and counselling services by age, disability and location: Health, FSC, CCC, Seif Ples, Empower Pacific
- Policy Outcome 4: Perpetrators are held accountable and rehabilitated
    - Number of integration programs; number of men reached
- Policy Outcome 5: National commitments are developed and coordination is improved
    - Funding

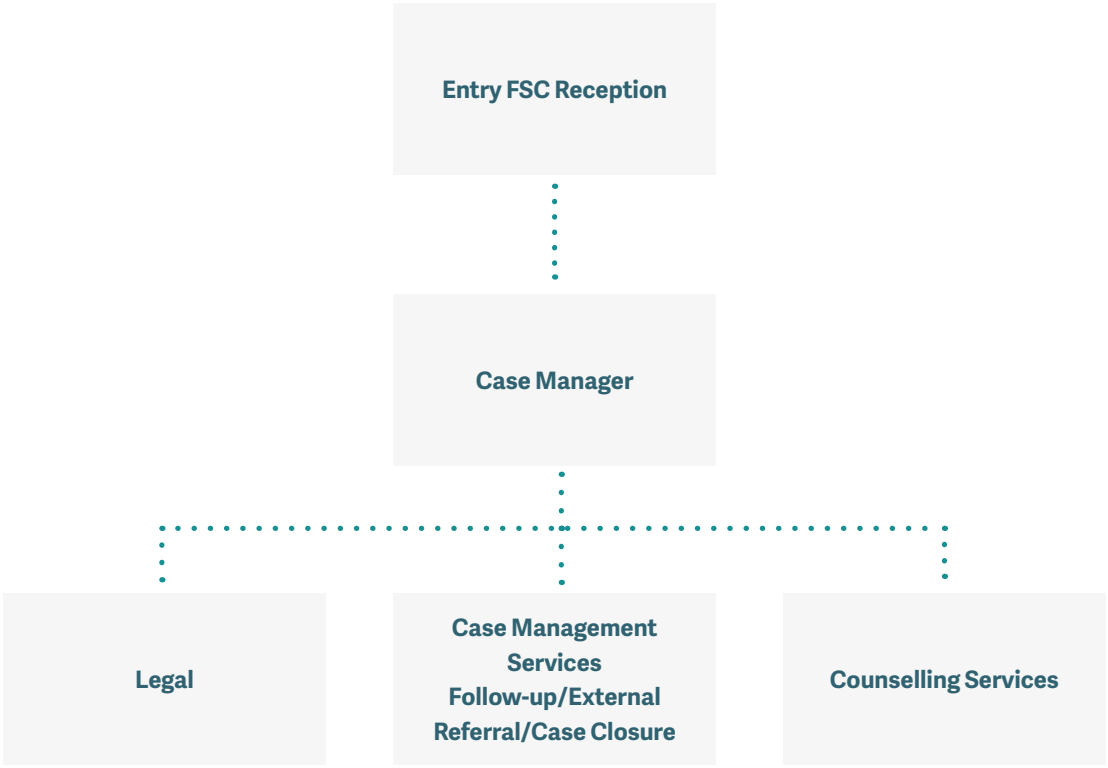
4) Recording SGBV in the MHMS Health Information System (HIS) (as per National Clinical Practice Guidleines)

- Case numbers are to be recorded on the HIS monthly form by category of:
- Sexual violence against women aged 18 and above
- Physical violence against women aged 18 and above (by intimate partner or family member)
- Child sexual abuse (below 18 years of age)
- Child physical abuse (below 18 years of age)
- Numbers of women subjected to violence who receive comprehensive health services
- SAFENET referrals made

5) Justice Information Management System (JIMS)

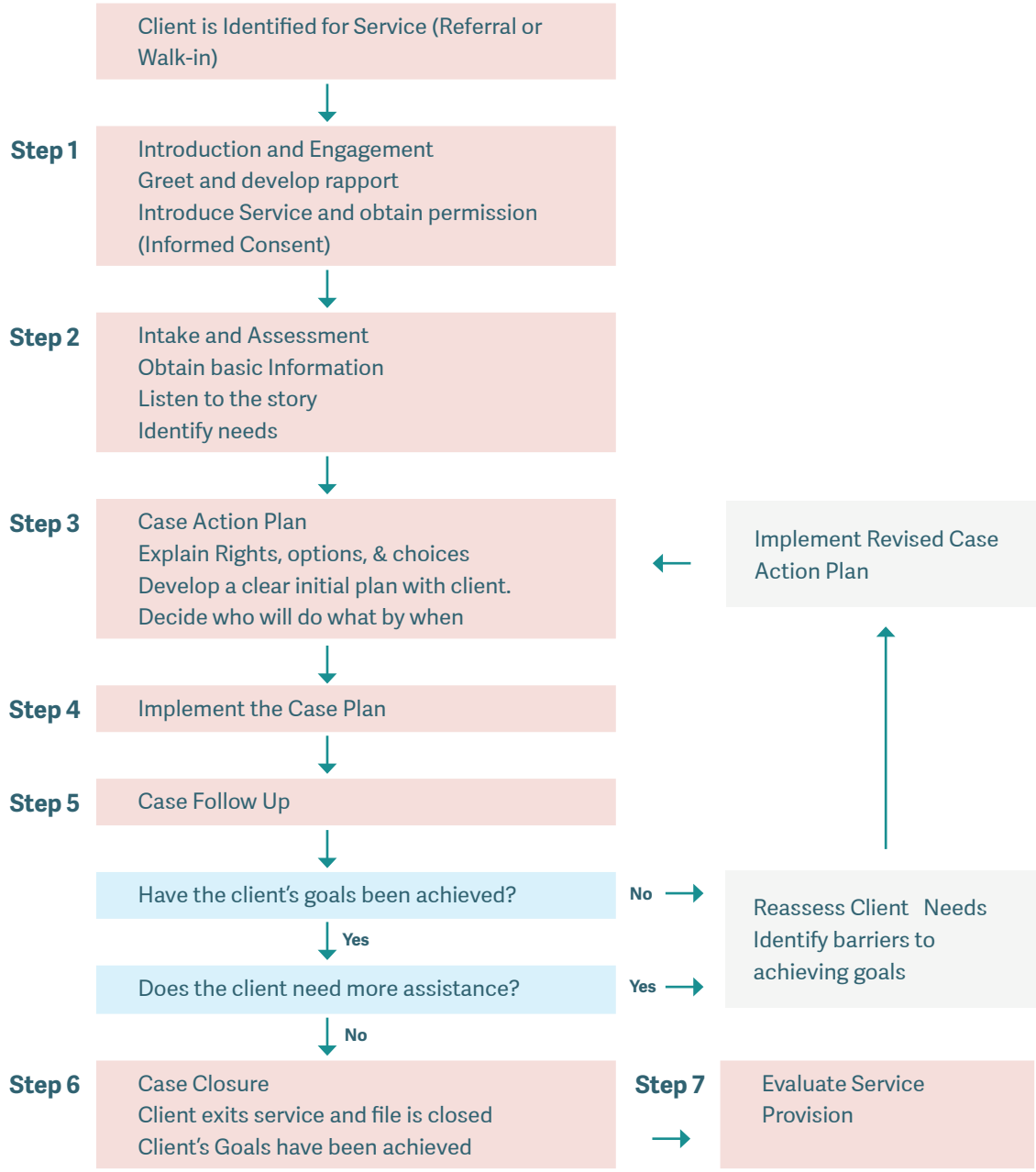
Section VI: SAFENET Member Organization Standard Operating Procedures

Family Support Centre Standard Operating Procedure

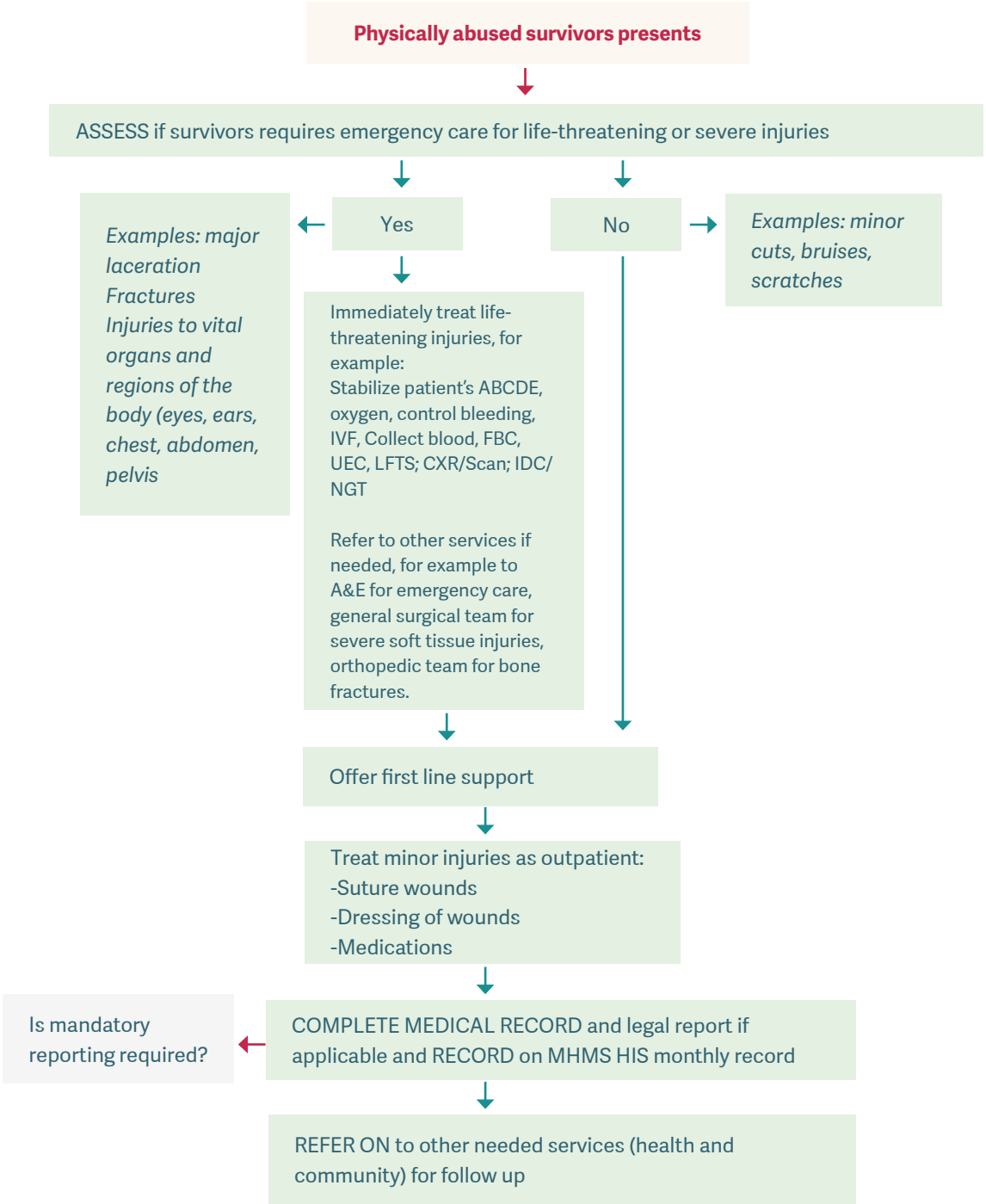


SAFENET SGBV Services / Accompaniment / RSIPF / CCC / SWD / HCC / NRH

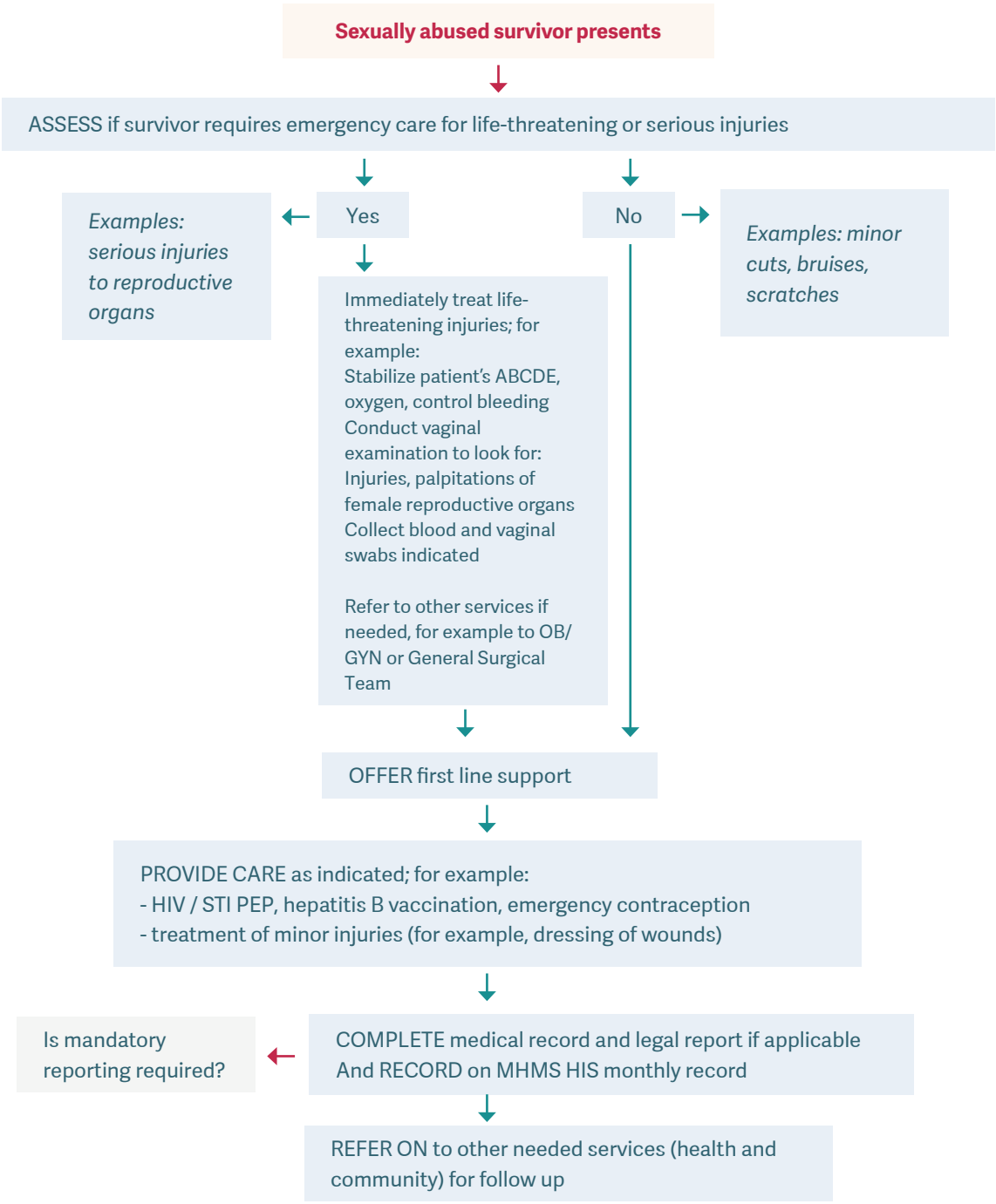
SAFENET: Case Management Process



MHMS STANDARD OPERATIVE PROCEDURE FOR PHYSICAL ABUSE



MHMS STANDARD OPERATIVE PROCEDURE FOR SEXUAL ABUSE



MHMS General assessment of mental health status

Assessing mental status begins with observing and listening closely. Take note of the following items; if problems with mood, thoughts or behaviour become evident, the survivor may have more severe mental health problems.

Appearance and behaviour	• Does she take care of her appearance? • Are her clothing and hair cared for or in disarray? • Is she distracted or agitated? • Is she restless, or is she calm? • Are there any signs of intoxication or misuse of drugs?
Mood, both what you observe and what she reports	• Is she calm, crying, angry, anxious, very sad, without expression?
Speech	• Is she silent? • How does she speak (clearly or with difficulty)? Too fast/too slow? • Is she confused?
Thoughts	• Does she have thoughts about hurting herself? • Are there bad thoughts or memories that keep coming back? • Is she seeing the event over and over in her mind?
Responses to general questions	• "How do you feel?" • "How have things changed for you?" • "Are you having any problems?" • "Are you having any difficulties coping with daily life?"

Adapted from: *Health care for women subjected to intimate partner violence or sexual violence, A clinical handbook.* Geneva: World Health Organization; 2014.

Please refer to the mhGAP Intervention Guide (mhGAP-IG) for further information about assessment and treatment of more severe mental health problems such as depression, psychosis, bipolar disorders, developmental and behavioural disorders in children and adolescents, alcohol use disorders, drug use disorders, and self-harm/suicide.

Available at: http://www.who.int/mental_health/publications/mhGAP_intervention_guide/en/).

STANDARD MEDICAL REPORT FORM PHYSICAL/SEXUAL ABUSE CASES

PART ONE: CONSENT FORM

Name of facility:

I, _____ , (print name of Survivor) authorize the above-named health facility to perform the following (tick the appropriate boxes):

	Yes	No
Conduct a medical examination	☐	☐
Conduct pelvic examination	☐	☐
Provide evidence and medical information to the police and/or courts concerning my case; this information will be limited to the results of this examination and any relevant follow-up care provided. *Please explain any limits of confidentiality, for example in case of mandatory reporting requirements for child abuse cases.*	☐	☐

I understand that I can refuse any aspect of the examination I don't wish to undergo.

Signature:

Date:

Witness:

PART TWO: BACKGROUND INFORMATION

1.DATE AND PLACE DETAILS

Clinician name:			Health Care Facility Location:	
Date/Time of presentation to MHMS:			In the presence of:	
Referral source:	☐ Police	☐ Crisis Support Agency	☐ Friend	☐ Other Health Facility _____
	☐ Self	☐ Counsellor	Relative _____	☐ Other (please specify): _____

2. CLIENT DETAILS

Client's name:			Sex: ☐ Male ☐ Female	
Date of birth:				
Address:				
☐ Adult (over 18)	☐ Adolescent (13-17)		☐ Child -(under 13)– Name of parent/guardian:	
Ethnic Background: (statistical purposes only)	☐ Melanesian ☐ Polynesian ☐ Micronesian	☐ European ☐ Chinese ☐ Indian		☐ Other _____

3. INCIDENT DETAILS

Perpetrator Name:	Sex: ☐ Male ☐ Female	
Relationship to Victim	Current Location of Perpetrator	
Place of Assault:	Home Village of Perpetrator:	
Date of Incident:	Time of Incident:	
Detail of Incident (survivor's story):		

Physical violence	Yes	No	Describe type and location on body	
Type (beating, biting, pulling hair, etc.)				
Use of restraint(s)				
Use of weapon(s)				
Drugs / alcohol involved				
Penetration	**Yes**	**No**	**ot sure**	**Describe (oral, vaginal, anal, type of object)**
Penis				
Finger				
Other (describe)				
	Yes	**No**	**Not sure**	**Location (oral, vaginal, anal, other)**
Ejaculation				
Condom used				

If the survivor is a child, also ask: Has this happened before? When was the first time? How long has it been happening? Who did it? Is the person still a threat?

PART TWO: BACKGROUND INFORMATION

4. GENERAL ASSESSMENT DETAILS

Date/Time of Assessment:		Triage to Assessment Delay:	min/hours
Providers present:	☐ Doctor (state name): _____		☐ RSIPF _____
	☐ Nurse (state name): _____		☐ Other _____
Incident visit type:	☐ Acute sexual assault	☐ Child Physical or Sexual Assault (Under 18 years of age)	☐ Physical Assault
Police involved: ☐ Yes ☐ No		☐ Forensic examination	☐ Non Forensic examination
Durations:	Face to face (Doctor): min	Paperwork (Doctor): min	Total (Doctor): min
	Face to face (Nurse): min	Paperwork (Nurse) min	Total (Nurse): min
Percentage time spent on following provisions:			
Sexual health management: %	Forensic management: %	Physical injury management: %	Mental wellbeing: %

5.MEDICAL DETAILS

Medical History					
After the incident, did the survivor	Yes	No		Yes	No
Vomit?			Rinse mouth?		
Urinate?			Change clothing?		
Defecate?			Wash or bathe?		
Brush teeth?			Use tampon or pad?		

Contraception use					
Pill		IUD		Sterilisation	
Injectable		Condom		Other	

Menstrual / obstetric history	
Last menstrual period	Menstruation at time of event: ☐ Yes ☐ No
Evidence of pregnancy ☐ Yes ☐ No	Number of weeks pregnant _____ weeks

History of consenting intercourse (only if samples have been taken for DNA analysis)		
Last consenting intercourse within a week prior to the assault	Date:	Name of individual
General existing health status		

Existing health problems
Allergies (if any)
Current medication (if any)

Vaccination status	Vaccinated	Not Vaccinated	Unknown	Comments
Tetanus				
Hepatitis B				
HIV / AIDS status	Known		Unknown	

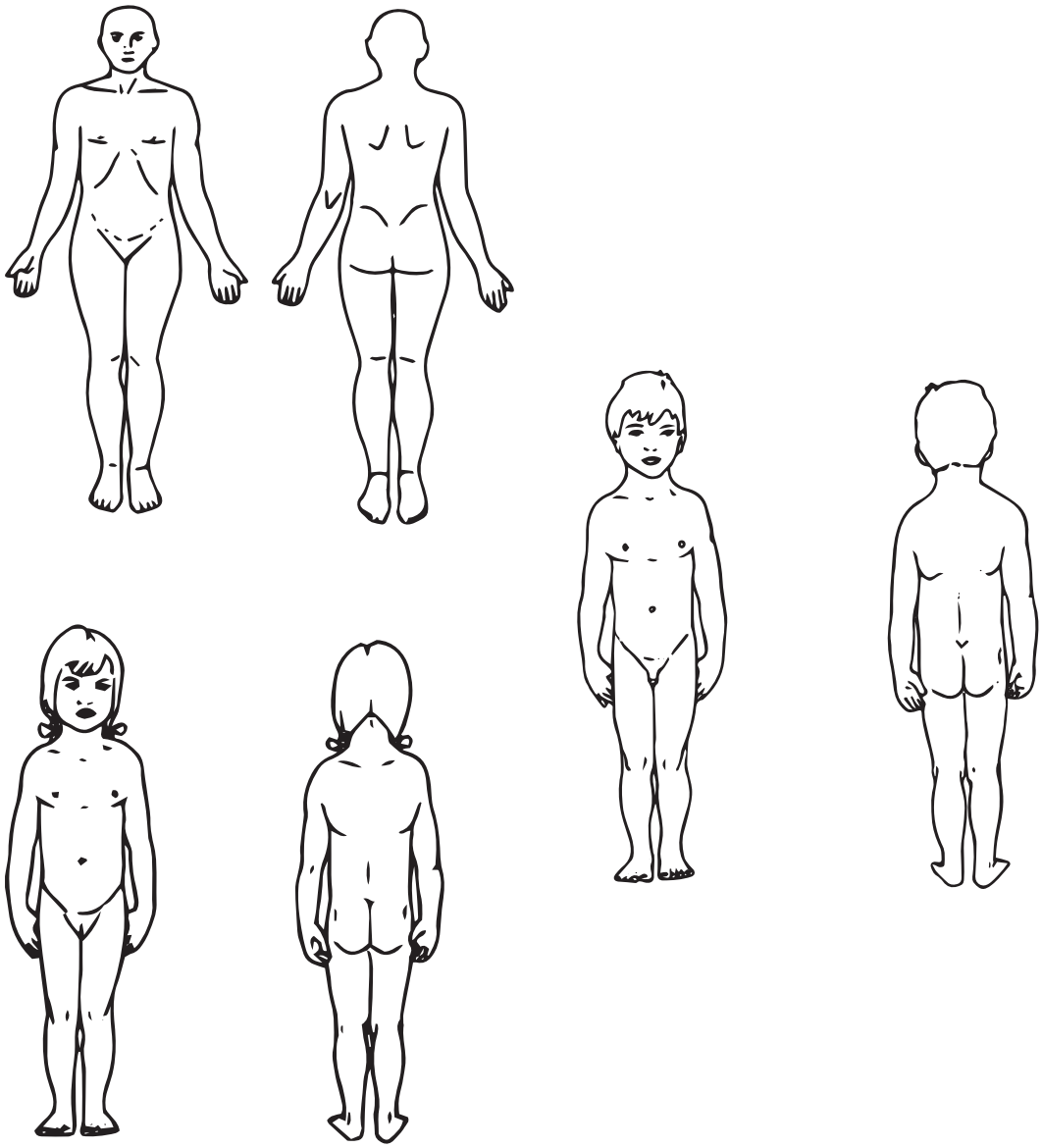
Medical Assessment
Appearance (clothing, hair, obvious physical or mental disability)
Mental state (calm, crying, anxious, cooperative, depressed, other)

Physical findings

Describe systematically, and draw on the attached body pictograms, the exact location of all wounds, bruises, petechiae marks, etc. Document type, size, colour, form, and other particulars. Be descriptive—do not interpret the findings.

Head and face	Mouth and nose	Eyes and ears
Neck	Chest and Abdomen	Back
Buttocks	Arms and hands	Legs and feet
Vulva / scrotum	Introitus and hymen	Anua
Vagina / penis	Cervix	Bimanual / rectovaginal examination

Body Mapping of Injuries



Type and location (vaginal swabs, blood samples, etc.)	Examined / sent to laboratory	Result

7. TREATMENTS PRESCRIBED

Treatment	Yes	No	Type and Comments
STI prevention / treatment			
Emergency contraception			
Wound treatment			
Tetanus prophylaxis			
Hepatitis B vaccination			
PEP for HIV			
Other			

8. REFERRALS AND FOLLOW UP

MHMS Referral:	☐ Medical Specialitst	☐ Social Welfare	
	☐ Mental Health	☐ Other (please specify):	_____
Survivor has a safe place to go	☐Yes ☐No	Has someone to accompany her/him	☐ Yes ☐ No
Survivor plans to report to police OR has already made report	☐ Yes ☐ No		
If the survivor is a child, have you notified a social welfare officer or police officer?	☐ Yes ☐ No		
Follow-up arrangements:	☐ SAFENET	(area?)_____ ☐ Family Support Centre ☐ Christian Care Centre	☐ Other (please specify): _____ ☐ RSIPF ☐ Social Welfare
Comments:			

PART THREE: DECLARATIONS

I have personally assessed the client and to the best of my knowledge the information given is true and correct.	
Printed name:	Title:
Signature:	Date:

Integrated Mental Health Services (IMHS) Standard Operating Procedure

Psychological First Aid (PFA) & Referral 'Red Flags'

Has client suffered from a recent episode of sexual or family violence?

YES

Provide Medical Care & PFA
Assess immediate needs / concerns
Promote SAFETY:
**provide an environment that is safe both physically and psychologically
Restore functioning:
**Restore psychological functioning by speaking in a slow calm voice and expressing confidence in the survivor's ability to cope
** Restore social functioning by connecting the survivor with supportive family members, friends, and community
Support appropriate Action:
** reduce uncertainty by providing clear information
**restore a sense of control by assisting the survivor to identify choices and options
**Enable the survivor to identify steps needed to establish a realistic safety plan

NO

but
indications of
**** a history of violence**
**** ongoing violence**

Shelter
If the survivor is too afraid to return home

If the perpetrator is waiting for them and is threatening harm

Christian Care Centre (CCC

Mental Health
If the survivor appears to be a danger to her/ him self or others

If yot suspect that the survivor has a mental disorder

After PFA, the survivor remains disoriented or unresponsive

Mental Health Deaprtment (NRH)

Social Service
If the survivor needs:

Legal Assistance
Welfare Services
Police
Maintanence
Child Protection

Family Support Services (FSC)
Social Welfare Division (SWD)
Public Solicitors Office (PSO)

Therapeutic Counselling
If the survivor requests counselling or emotional support
If the survivor continues to be overwhelmed

If the survivor is a child or disabled person and the guardian/parent does not appear supportive

If the survivor is not functioning in their daily tasks or routine

Family Support Services (FSC)

Social Welfare Division
Standard Operating Procedure

Christian Care Centre
Standard Operating Procedures

Public Solicitors Office
Standard Operating Procedure

Civil or Family Matter

3 entry points
- SAFENET
- Walk-ins
- Legal Clinics

Legal Officer

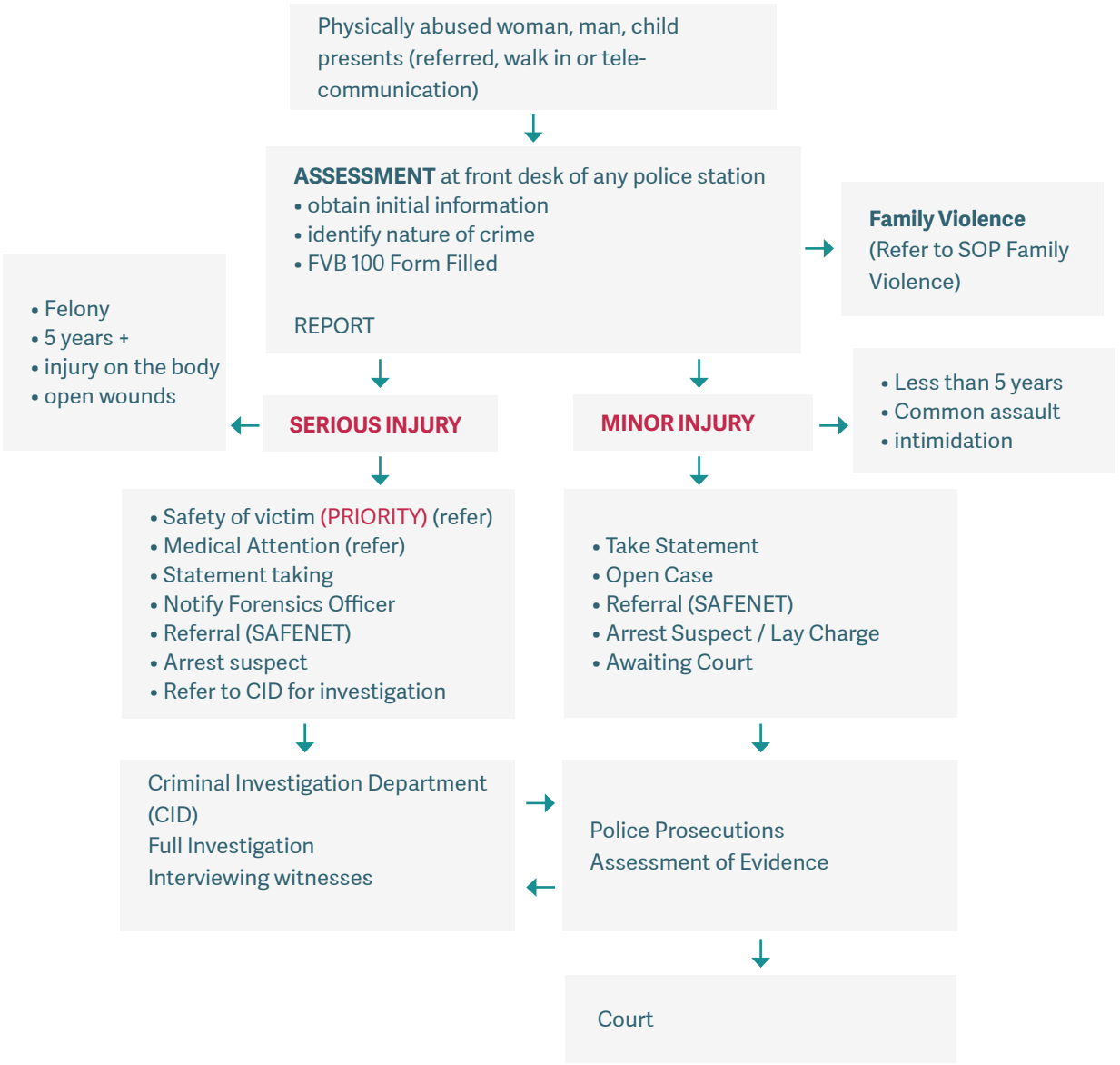
Family Protection Unit
police safety notice
protection orders
child maintenance
urgent access applications

Criminal Unit
perpetrators breach of PSN/IPO/FPO
direct charges under FPA

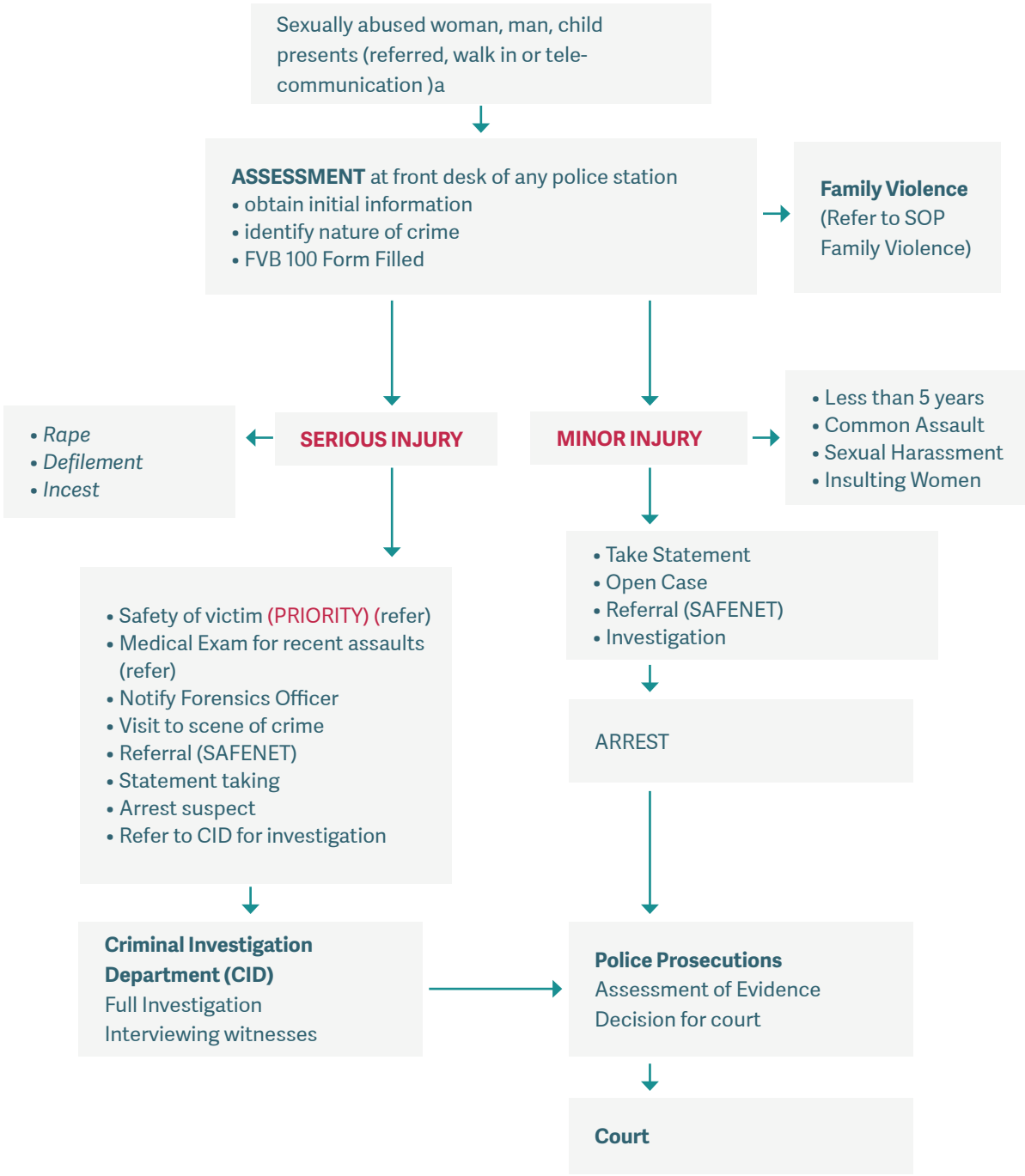
Court

- Magistrates Court (minor offences)
- High Court (serious offences)

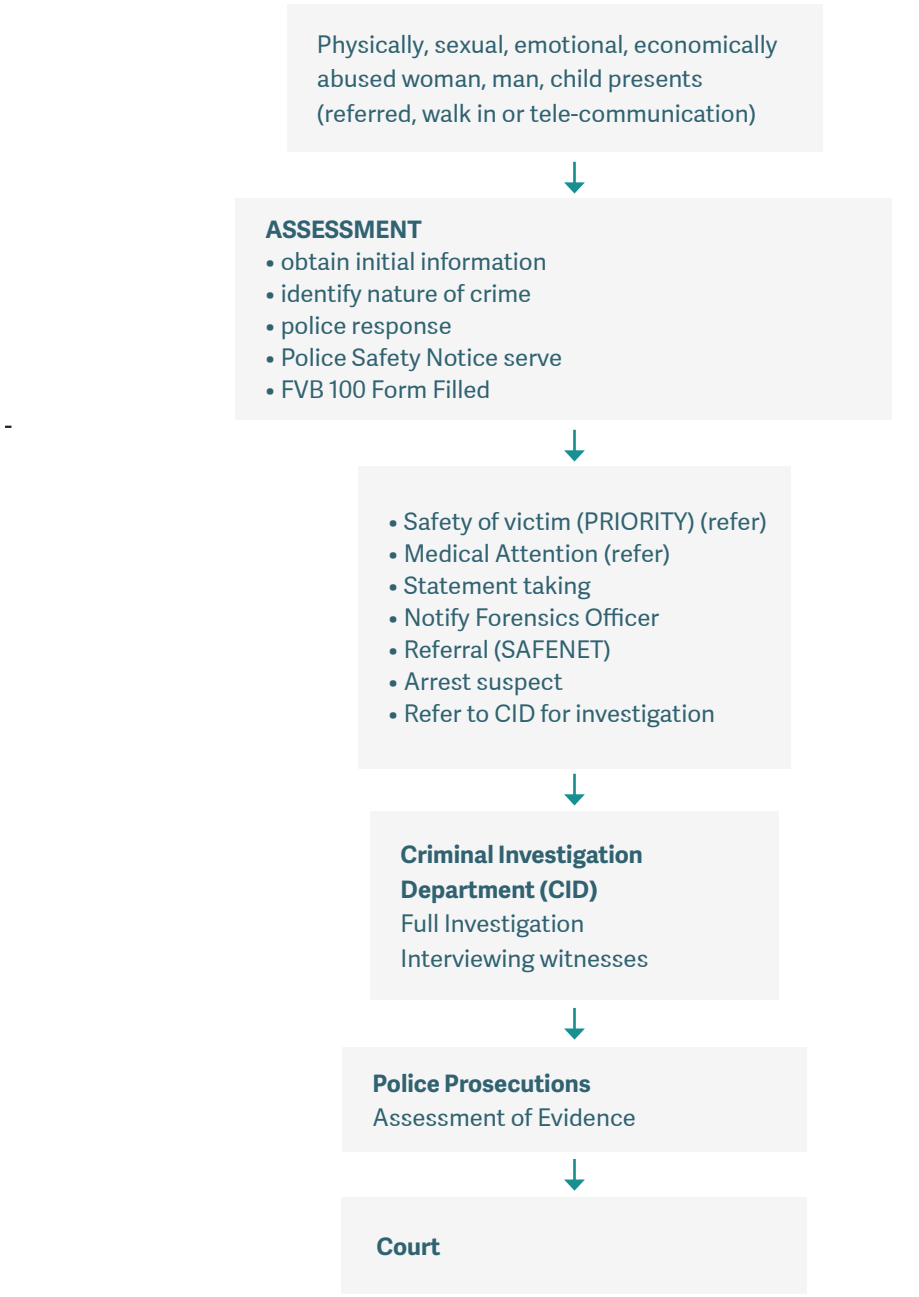
Royal Solomon Island Police Force
Standard Operating Procedure Physical Assault



Standard Operating Procedure Sexual Assault



Royal Solomon Island Police Force
Standard Operating Procedure Family Violence



Section VII: Annexes

Annex 1: Definition of Common Terms

Key Term	Explanation
Abuse	Abuse is the misuse of power through which the perpetrator gains control or advantage of the abused, using and causing physical or psychological harm or inciting fear of that harm. Abuse prevents persons from making free decisions and forces them to behave against their will.
Attempted Rape	Involves a sexual assault in which there was an attempt at rape, but no penetration. The assault may have involved forcing the woman to perform sexual acts that she did not want to do or that she did not like.
Child	Is a person who is under the age of 18 years. In the CWA Child this does not include a child who is or has been married (CWA 2017 Part 1).
Child Neglect	A failure to exercise parental responsibility to provide for the child's basic physical (food, clothing, shelter, medical), intellectual (education, guidance), emotional or social (customs, traditions, religious, spiritual values) needs, including any special needs in relation to disability (CFWB 2013).
Child Sexual Abuse	There are many different definitions of child sexual abuse. Most commonly child sexual abuse takes place when an adult or someone older than a child involves a child in sexual activity, 'that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared and cannot give consent, or that violates the laws or social taboos of society' (WHO). Child sexual abuse includes a wide range of sexual activity – sexual touching (breasts, genitals, anus), oral sex, sexual intercourse, vaginal penetration with fingers, penis or any other object, child prostitution, child pornography, child sex rings (where adults regularly involve a group of children in sexual activity).
Coercion	Coercion is forcing, or attempting to force, another person to engage in behaviours against their will by using threats, verbal insistence, manipulation, deception, cultural expectations or economic power. Di
Defilement	Sexual intercourse between an adult and child under the age of 15.
Domestic Violence	Domestic violence is an act directed at the claimant or a person at risk, or a threat of such an act that harms or is likely to harm their safety, health or wellbeing. It may consist of a single act or a number of acts that form part of a pattern of behaviour, even though some or all of those acts when viewed in isolation appear to be minor or trivial. (Draft FPB 2014) A domestic relationship exists between a claimant and a respondent if: a) they are or were married to each other in accordance to law, custom or religion; b) they live or lived together in a relationship in the nature of marriage, although they are not, or were not, married to each other; c) they are the parents of a child or are persons who have or had parental responsibility together for a child; d) they are family members; e) they are or were in an engagement, courtship or customary relationship, including an actual or perceived intimate or sexual relationship of any duration; f) they share or recently shared the same residence; g) the claimant is wholly or partially dependent upon any form of care in the same household as the respondent; or h) the claimant is a domestic worker in the respondent's household.
Economic Abuse	Unreasonably controlling behavior which denies a person financial autonomy or prevents them from taking part in decisions over household expenditures or the disposition of joint properties; withholding financial support reasonably necessary for the maintenance of a person or of the person's household; or the unreasonable and unilateral disposal, retention or subtraction of moveable or immovable property in which a person has a material interest, or damage to or destruction of their personal property, so as to interfere with their use of such property. (draft FPB 2014)

Key Term	Explanation
Empowerment	It is both a process and the impact of a process. As a process, it is the means through which women and men are able to take control of their lives with confidence, knowledge, skills, self-esteem and self-respect. As an impact, it is the change that takes place at the personal level (consciousness, self-confidence, abilities, education and well-being) and structural change at the economic, political, social, cultural and legal levels.
Family Violence	Family violence and domestic violence are used inter-changeably in RSIPF documents. Family violence is defined as abusive or controlling behaviour by a family member or several family members (not confined to a legal relationship) over another. Primarily violence is directed towards women and children. Violence and abusive behaviour include: physical, psychological, sexual, economic and social.
Forced / early child marriage	The marriage of an individual against their will. Marriage before the age of 15 is considered an early child marriage and is illegal. Between the ages of 15 and 18 persons marrying need the written consent of a parent or guardian.
Gender-based Violence	Gender based violence is an umbrella term used to describe the gender dimensions of violent, abusive or harmful acts against women or men on the basis of their sex. The gender dimensions refer to the social norms of what it means to be a man and a woman in society. These norms change from one place to another and between cultures. In many societies around the world women have a disadvantaged position compared to men, they are perceived to be and treated as inferior to men. These are referred to as unequal power relations between women and men. The gender dimensions of violence are rooted in these perceptions, practices and hierarchies. Women's subordinate status in society increases their vulnerability to violence.
Incest	Sexual abuse that occurs within the family. Incestual abuse involves sexual activity between a child and her/his adult family members. Most often an incestual relationship involves a male adult (father, uncle, adult brother) and a female child. Incest involves blood relatives, half siblings, step and adopted children.
Perpetrator	A person who directly inflicts or supports violence or other abuse inflicted on another against his/her will.
Physical Assault / Abuse	Any violence or maltreatment that results in physical wounds or bodily injury.
Psychological / emotional Abuse	Acts or omissions causing or likely to cause mental or emotional suffering including patterns of belittling, denigrating, threatening, scaring, ridiculing, or other non-physical forms of degrading or rejecting treatment (CFWB 2013)
Rape	Is sex with any female person without their consent. Rape means penetration. Currently penetration in the Solomon Islands is only vaginal. Legal reform could expand it to include oral (in the mouth) and anal. Rape is, as such, only considered to apply to females. It is rape even if there is no physical force, no weapons, no cuts or bruises. Rape can occur between the same sex and opposite sex.
Sexual Assault	Sexual assault is a crime involving any unwanted act of sexual nature that is imposed on another person. This includes sexual assault in a marriage or dating relationship. The range of behaviours considered as sexual assault include rape (i.e. unwanted sexual intercourse), unwanted fondling and touching.
Sexual Harassment	Any unwanted sexual attention in the workplace. It can involve unwanted comments, suggestions, sexualised talk, looks, repeated propositions for dates / dinner, demands for sexual intercourse, touching, sexual insults, threats of demotion and job loss for not having sex, promised favours of promotion for sex. Harassment can also take place in non-working situations where a person in 'authority' and respect exploits their position of trust and power.
Survivor-centered approach	Survivor centered services place the survivor at the center of the helping and referral process. They create a supportive environment in which the survivor's rights are respected and she is treated with dignity and respect. All actions revolve around her needs, her rights and her decisions. The survivor leads decision making through the choices she makes for support

Key Term	Explanation
Survivor /Victim	A person who has experienced gender-based violence. The terms "victim" and "survivor" can be used interchangeably, although "victim" is generally preferred in the legal and medical sectors, and "survivor" in the psychological and social support sectors. Throughout this SOP we use "survivor/victim".
Violence Against Women	Violence against women (VAW) is a technical (and political) term used to collectively refer to violent acts that are primarily or exclusively committed against women. Violence against women is a form of GBV. Most GBV is upon women. VAW is any form of violence against women that does, or is likely to, result in physical, sexual or psychological harm or suffering, including threats of violence and arbitrary deprivation of liberty, whether occurring in public or private life

SAFENET Response and Referral Pathway

Survivor Seeks Help from one of the SAFENET Providers:	
• Medical Services (NRH/HC/Seif Ples/ANC)	• Integrated Mental Health (MHS)
• Shelter (CCC/Seif Ples)	• Social Welfare Division (SWD)
• Police	• Family Support Center (FSC)
	• Legal (PSO)

Immediate Response Action used by all SAFENET Entry Points

Private Room to talk Safe/Caring environment	Informed Consent	First-line crisis support Psychological First Aid	Medical First Aid and **if less than 3 to 5 days since rape incident, access Essential Medicine quickly	Mandatory 3 Risk Assessment Questions Yes Response Flags High Risk Case And Mandatory Safety Planning	Offering Referral Options: 1. Case Management (for further assessment and support) or 2. Direct Referral to SAFENET Partners for service * Fill out SafeNet Referral Form

SAFENET Case Management Services call 26999 or 20619 (24 Hours)

- Case Manager comes to the survivor at the SAFENET entry point to offer services and support
- Case Manager completes a needs assessment and develops an Action Plan with the survivor
- Case Manager provides accompaniment and support until survivor's goals are met.

*SAFENET Referral Services

Medical Services	Mental Health	Shelter	Welfare / Child Protection	Counseling	Legal & Para-Legal Information	Police
If the survivor • Has physical injuries or • Has been sexually assaulted or raped Rape is a medical emergency. It is best to get all medicines within 3 days of the rape.	• If the survivor appears to be a danger to him/ her self or others (e.g. suicidal or violent) • If you suspect that the client has a mental disorder • If the client remains disoriented or unresponsive after PFA has been given.	• If the client is too afraid to return to their home. • If the perpetrator is waiting for the survivor and she is afraid to leave. • If the survivor reports perpetrator is continuing to threaten to harm her or others.	• If you are a health care worker and suspect that a child has been abused, the Family Protection Act (FPA) requires that you make a report. • If a child has been abused and it is unclear if the caregiver can keep the child safe.	• If the survivor requests counseling or emotional support • If the survivor continues to be overwhelmed after receiving basic first-line support/PFA • If the survivor is a child or disabled person and the guardian/parent does not appear supportive. • If the survivor is not functioning in their daily tasks or routine.	• If the survivor needs Information about legal options • If the survivor needs legal assistance with • maintenance, • divorce, • custody	If the survivor needs • immediate protection • help to return to her home to collect personal items • Police Safety Notice
1. National Referral Hospital Emergency Department 2. Health Centers: Gender Focal Points 3. Seif Ples Model Sites	1. Integrated Mental Health Service at NRH 2. In Provinces -Mental Health Focal Point	1. Seif Ples Model Sites • Short stay:1-3 days 2. Christian Care Center • 1-2 weeks	Social Welfare Division Child Abuse Reporting Child Protection Services	1. Family Support Center • Empowerment Counseling • Therapeutic Counseling: 2. IMHS 3. Pastoral/ spiritual counseling at CCC or various churches	1. Public Solicitor's Office 2. Family Support Center 3. Authorized Justices	Police • 24 hour 999/23666 • Central Police 22266 • Henderson 36200 • Family Violence Unit 28275

In provinces see local referral pathway, where available, for services

ANNEX 3: Contact List and Key Services
ROYAL SOLOMON ISLANDS POLICE FORCE (RSIPF)

KEY INFORMATION DOCUMENT

KEY SERVICES:

- Receive and attend SGBV/FV reports/complaints
- Provide security from immediate harm for victims/survivors of SGBV/FV
- Issue and serve police safety notices for the protection of victim/survivor as per the Family Protection Act
- Investigate reports of SGBV/FV and collect evidence
- Make applications to the Court for Interim Protection Order (IPO) and Final Protection Order (FPO) for the protection of victim/survivor
- Serve IPOs and FPOs and explain the purpose, duration, effect and consequences of breaching the IPO / FPO, and any variations to either to perpetrators;
- Prosecute report/complaints of SGBV/FV
- Arrest perpetrators of SGBV/FV
- Collate data and report regular on SGBV/FV
- Public awareness campaigns against SGBV/FV
- Safety and well-being support for children at risk

LOCATION:

Police Headquarters, Rove, Honiara

CONTACT DETAILS: (MON – SUN)

GENERAL CLIENT ENQUIRIES PSN / PO (8 – 4pm)	AFTER HOURS/EMERGENCIES
Name: Mary Maneforu	Name: Solomon Sisimia
Position: Family Violence Unit Coordinator	Position: Dir. Community Policing & Family Violence Unit
Phone: (677) 28275	Phone: (677) 999 – Police Call Centre
Mobile: (677) 7472126	Landline: 23666
Email: Mary.maneforu@rsipf.gov.sb	Email: Solomon.sisimia@rsipf.gov.sb

REFERRAL SAFENET CONTACT	AFTER HOURS/EMERGENCIES
Name: Solomon Sisimia	Name: Rose Nala
Position: Dir. Community Policing & Family Violence Unit	Position: Sexual Assault Unit Coordinator
Phone: (677) 28275	Phone: (677) 999 – Police Call Centre
Mobile: (677) 7481753	Mobile: (677) 7477999
Email: Solomon.sisimia@rsipf.gov.sb	Email: Rose.nala@rsipf.gov.sb

EMERGENCY DEPARTMENT, NRH

KEY INFORMATION DOCUMENT

KEY SERVICES:

- Medical services (emergencies, outpatient minor injuries, Sexually Transmitted Infections (STI)/ HIV) for women, men and child survivors/ victims SGBV/FV including child physical and sexual abuse
- Immediate access to PEP/rape kits and emergency contraceptives;
- Referrals onto other SAFENET services (health, case management, police, shelter, counselling)
- Reporting child physical or sexual abuse to social welfare and/or police
- Medical - legal reports for police and/or courts
- Collate data and report regularly on SGBV/FV from MHMS HIS monthly record

LOCATION:

National Referral Hospital

CONTACT DETAILS:

SAFENET CONTACT #1	AFTER HOURS/EMERGENCIES
Name: Dr. Trina Sale	Name: On Call Doctor
Position: Director ED, NRH	Position: On Call Doctor
Phone: 23600 ext. 313 or 244	Phone: 23600 ext. 313/ 24452
Mobile: 7635494	
Email: tirisale@yahoo.com	

SAFENET CONTACT #2	REFERRAL SAFENET/GBV / POLICY CONTACT
Name: Dr. Patrick Toito'ona	Name: Dr. Jacinta Ramo
Position: Deputy Director ED, NRH	Position: Registrar Assigned to GBV
Phone: 23600 Ext. 313	Phone: 23600 Ext. 313
Mobile: 7498509	Mobile: 8811385
Email: ptoitoona@gmail.com	Email: jramo@nrh.gov.sb

FAMILY SUPPORT CENTRE

KEY INFORMATION DOCUMENT

KEY SERVICES:

- Crisis and therapeutic counselling for survivors (women, men and children)
- Legal advice and representation (women, men and children survivors)
- Case management services including accompaniment and follow-up to medical facilities, Police, Christian Care Centre, Public Solicitor Office and Courts
- Referral to other SAFENET SGBV service providers
- Awareness raising and campaigns on gender equality, Gender Based Violence including child abuse, sexual abuse and rape; human rights with a specific focus on women's and children's rights; Solomon Islands laws and the penal code including the Family Protection Act (nationally, communities, secondary schools, upon request from organizations)
- Radio and media programs and public presentations on the above themes
- A resource/ reference library with materials on gender, gender based violence and human and women's rights available to professionals, groups, students and individuals
- Collate data and regular reports on SGBV/FV

LOCATION:

Outback Building on Rove Highway beside the Children's Park

CONTACT DETAILS:

GENERAL CLIENT ENQUIRIES	AFTER HOURS/EMERGENCIES
Name: Leona Sango	Name: Andella James (or identified person on duty)
Position: Receptionist	Position: Senior Counselor/ counselor or case manager
Phone: 26999 / 20619	Phone: no after hours landline
Mobile: 20619	Mobile: 20619
Email: fsc@solomon.com.sb	

REFERRAL SAFENET/POLICY CONTACT
Name: Lynffer Maltungtung
Position: Center Manager
Phone: 26999/ 20619
Mobile: 7895414
Email: lmaltungtung.fsc@gmail.com

CHRISTIAN CARE CENTRE

KEY INFORMATION DOCUMENT

KEY SERVICES:

- Temporary shelter (MAXIMUM of 14 days)
- Basic faith-based/pastoral counseling (women and children)
- Referral and Accompaniment to other SGBV services
- Collated data and regular on SGBV/FV
- Public awareness campaigns against SGBV/FV

LOCATION:

Tenaru, with small office in Point Cruz, at Patteson House

CONTACT DETAILS:

GENERAL CLIENT ENQUIRIES	AFTER HOURS/EMERGENCIES
Name: Sr. Phyllis Margaret Sau	Name: Sr. Phyllis Margaret Sau
Position: Coordinator	Position:
Phone: 23363	Phone: M 7443339
Mobile: 7418842	Mobile: 7418842 / 7651223
Email: ccc@solomon.com.sb Phyllissauu@yahoo.co.uk	

REFERRAL SAFENET/POLICY CONTACT
Name: Fr. Nigel Ktuata
Position: Mission Secretary/ Vice-Chair ccc
Phone: 21671
Mobile: 7784332
Email: nigelosktuata@gmail.com

SOCIAL WELFARE DIVISION

KEY INFORMATION DOCUMENT

KEY SERVICES:

- Respond to suspected cases of children at risk
- Assessment and collection of information of child welfare / protection cases for children at risk
- Referral to the police for crimes committed against and involving children
- Information management system on children at risk and their family members and guardians
- Strengthen family and community practices in regard to care and protection of children through prevention programs
- Timely referrals, information sharing and coordination between all service providers in regards to a child's welfare
- Family meetings to discuss well-being protection of the child
- Care and protection plans for a children at risk
- Application for care and protection orders for children at risk
- Emergency removal orders for children at risk and arrangements for temporary safe shelter
- Reports to court for final protection orders

LOCATION:

Ministry of Health Headquarter- China Town

CONTACT DETAILS:

GENERAL CLIENT ENQUIRIES (8-4pm)	AFTER HOURS/EMERGENCIES
Name: Agnes Ofasia	Name: Nashley Vozoto
Position: Secretary	Position: GBV Program Coordinator
Phone: 20569	Phone: 20686 working hours
Mobile:	Mobile: 7499637
Email: AOfasia@moh.gov.sb	Email: NVozoto@moh.gov.sb

REFERRAL SAFENET/POLICY CONTACT
Name: Linda Tupe
Position: Director SWD
Phone: 20569
Mobile:
Email: LTupe@moh.gov.sb

PUBLIC SOLICITOR'S OFFICE (PSO)

KEY INFORMATION DOCUMENT

KEY SERVICES:

- Applications to the Court for Interim Protection Orders / Final Protection Orders
- Provide legal advice for less urgent report/complaints
- Assist and write warning letter to respondents/perpetrators
- Legal services and advice as required by the client, e.g. return of child, custody, maintenance, removal from home, access, and other follow up;
- Court appearances;
- Referral to appropriate services (safety, counselling, medical, legal, shelter) within SAFENET
- Collate data and report regularly on SGBV/FV
- Public awareness campaigns against SGBV/FV

LOCATION:

2nd Floor Placemakers Building, opposite Central Market

CONTACT DETAILS: (MON – FRI)

GENERAL CLIENT ENQUIRIES (8 – 4pm)
Name: Receptionist
Position: Front Desk
Phone: (677) 28406 / 22348

LEGAL ADVISE /POLICY ENQUIRIES (8 – 4pm)
Name: Kathleen Kohata
Position: Principal Legal Officer
Phone: (677) 28406/22348
Email: KKohata@pso.gov.sb

MINISTRY OF WOMEN, YOUTH, CHILDREN AND FAMILY AFFAIRS (MWYCFA)

KEY INFORMATION DOCUMENT

KEY SERVICES:

- Sit on the Family Protection Advisory Council (FPAC)
- Administer Parts 4 and 5 of the FPA
- Develop and keep a current electronic register of Domestic Violence (DV) counselors
- Monitor the register on a regular basis
- Develop and approve a code of ethics for DV counselors
- Monitor counselors and deregister those that contravene a code of ethics
- Establish and support public awareness programs aimed at preventing DV
- Report impacts of public awareness campaigns to Cabinet and parliament

LOCATION:

4th Floor, Anthony Saru Building

CONTACT DETAILS: (MON – FRI)

GENERAL & POLICY ENQUIRIES (8 – 4pm)
Name: Goldi Lusi / Pauline Soaki
Position: Dir. Children / Dir. Women
Phone: (677) 23544
Mobile: (677)
Email: glusi@mwycfa.gov.sb psoaki@mwycfa.gov.sb

Annex 4:

CASE MANAGER/DRIVER SAFETY LOG PROCEDURE

Step One: Any case manager or driver leaving to do FSC business needs to register their activity with the receptionist

Step Two: the receptionist documents the following items:
- Phone Contact – test if phone working and check if top up is needed
- Time of Departure
- Destination
- Anticipated return time: the receptionist will do a safety check if you are taking too long.

Step Three: The case manager/driver will call the receptionist if the plans or destination changes, or if the activity will take longer than anticipated.

The Safety Check-ins should happen every hour.

If the case manager does not call, the receptionist will call and write down the time.

Step Four: When the case manager/driver returns, the time will be noted and no further follow up is needed.

Other follow up that may be needed:
- If the case manager or driver reports immediate danger,
  - ask for their location and stay on the phone with them,
  - Notify the FSC supervisor,
  - Call the Police
- If the case manager or driver do not appear to be comfortable for any reason (e.g. safety worries, people in the environment are not supportive, etc.)
  - Notify the FSC supervisor
  - Encourage them to return to the FSC for review of the Action Plan with the FSC Supervisor.
- If the receptionist needs to take her lunch break or to leave work early, she will hand over the log to another person to manage it until she returns.

REMEMBER: SAFETY OF THE CLIENT AND THE STAFF ALWAYS COMES FIRST!

Annex 5: Case Manager/Driver Safety Log

Date	Name of Case Manager and/or Driver	Phone Contact	Time of Departure	Destination	Anticipated Return time	Hourly Safety Check-in Times	Return Time

Annex 6: SAFENET Referral Form

CLIENT NUMBER		
1. Risk Category		
High Risk Case ☐ (Needs safety planning and immediate protection)	Low Risk ☐ (Normal Process)	
Safety issues of concern		
Does the perpetrator knows where client is No ☐ Yes ☐		
Does the victim/survivor think the perpetrator will try to find her/him here? ☐ No ☐ Yes	Will the victim/survivor be in immediate danger when leaving here? ☐ No ☐ Yes	
How safe does victim/survivor feel at home right now? 1 ☐ Very Safe 2 ☐ 3 ☐ 4 ☐ 5 ☐ Not Safe At All		
2. Referral and Service Details		
Service provider		Phone Contact
Date and time presented to your Facility: (Day/Month/Year) (time of day)		
Referral Source to Service Provider ☐ CCC ☐ FSC ☐ PSO ☐ RSIPF ☐ SWD	☐ NRH ☐ IMHS ☐ SP ☐ Friend ☐ Family ☐ Church	☐ Self ☐ Other If other, who?

3. Client Details

Client health conditions or disabilities:

Sex	Age	Marital Status	History of Violence
☐ Male ☐ Female			☐ No ☐ Yes

Number of Times Reported in Past	Permission to Contact Client
	☐ No ☐ Yes - how? _____

4. Incident and Perpetrator Details

Relationship to perpetrator

Sex	Age	Date and Time of Incident: (Day/Month/Year)
☐ Male ☐ Female		

Place of violence

Aggravating Factor(s)

Weapon / object used_____

Alcohol / Drugs _____

Main presenting complaint

- ☐ 1. Physical Abuse (IPV/child)
- ☐ 2. Sexual Abuse/assault
- ☐ 3. Trafficking/exploitation
- ☐ 4. Family conflict
- ☐ 5. Economic/property abuse
- ☐ 6. Child Abduction/reunification
- ☐ 7. Child Neglect/abandonment
- ☐ 8. Divorce/Separation
- ☐ 9. Maintenance/custody
- ☐ 10. Witnessing abuse/violence
- ☐ 11. Other family issues: _____
- ☐ 12. Mental Health conditions (e.g. depression, anxiety, trauma)

Frequency and duration of the problem:	Other issues of concern for the client:

Has the client reported this incident anywhere else?

- ☐ No
- ☐ Health/Medical Services
- ☐ Counseling Services
- ☐ Police/Security (indicate if Public Safety Notice been issued)
- ☐ Legal Assistance Services
- ☐ Community Based Program
- ☐ Safe House/Shelter
- ☐ Other (specify) _____

5. Consent

All relevant information about available SAFENET services has been provided (Informed Consent) ☐ Yes ☐ No

Client agrees to share/exchange information about case with SAFENET members

☐ Yes ☐ No

6. Client Goals

Client has an action plan with goals ☐ Yes ☐ No

Summary of client goals
7. Administration Details
Name and Title of Service Provider
Date (Day/Month/Year)
Name and contact details of SAFENET Case Manager Only:
Date (Day/Month/Year)

Annex 7: Basic Assessment Information Gathered by RSIPF

RSPIF gathers basic information

- The basic information RSIPF records for investigations:
- what happened;
- when the incident took place (date and time);
- where the incident took place;
- who was involved;
  - name and address of the victim
  - name and address of all witnesses
  - all available details about the suspect/offender, including his/her current location
  - the name and address of the person reporting the incident
- the date and time the report was made

Note: Section 11.5.9 of the Commissioners Orders on Family Violence stipulates that 'if the affected person wishes to withhold his or her address from the respondent, the affected person may leave the address field on the application blank and instead provide the address of the relevant court or authorized justice on a separate document. This applies for any application under the FPA 2014 that is required to be served on the respondent. It is imperative RSIPF officers inform the affected person of this right'.

Annex 8: Sector Specific Safety and Risk Requirements

Policy Source	Safety Theme	Text	Section
CWA	Fast Track	Guides all decision-making under the CWA requiring that decisions relating to children be implemented in a timely matter	Clause 11
	Care & protection plan	Sets out the preferred course of action for cases involving the protection of the child identifying a care and protection plan with the parents as a priority	Clause 25
	Care & protection plan	Provides the details of what should be included in the agreed care and action plan for a child	Clause 27
	Removal of Child	Provides details of removal of the child to a temporary safe place if a child is in immediate danger and/or there would be a substantial risk to the child	Clause 30
	Temporary safe place	Outlines where a child would be taken for a temporary safe place	Clause 32
	Expedite proceedings	Outlines the requirement to expedite proceedings	Clause 37
RSIPF CO /2016/NO/ 003	Safety /weapons	Investigation practice stipulates the responding officers shall investigate the incident thoroughly perform the following actions: • address the immediate safety of all parties involved including police officers; • take control of any weapons used or threatened to be used in the incident; • obtain medical assistance if required.	11.2.3
	Risk assessment	A PSN should be issued if the affected person is at risk of further family violence. RSIPF should investigate the family violence incident to determine the risk factor of the family situation and the likelihood of further family violence being committed. After investigating the family incident RSI peer will then be able to determine if PSN is appropriate. Affected person should never be asked if they wish for a PSN to be issued	11.3.4
	Risk and reporting	All officers shall be aware of possible victim/witness intimidation or coercion and the increased danger when a victim decides to leave her abusive partner	11.5.7
	Risk & reporting	If an officer suspects occurrences of intimidation or coercion of the victim/ witness, the officer shall take all appropriate steps to ensure the safety of the affected person, and complete a written report to be delivered to the officer in charge of the case through the chain of command	11.5.8
	Non-identifying information / Withholding names	If the affected person wishes to withhold his or her address from the respondent, the affected person may leave the address field on the application blank and instead provide the address of the relevant court or authorize justice on a separate document. This applies for any application under the FPA 2014 that is required to be served on the respondent. It is imperative RSIPF officers inform the affected person of this right	11.5.9
	Offenses for threatening service providers	Person commits an offense under section 60 of the FPA 2014 if the person obstructs, threatens or intimidates a registered counsellor, healthcare provider or other support worker providing services to an affected person	11.9

Policy Source	Safety Theme	Text	Section
	Arrest & safety	After arrest consideration must be given to: • the welfare and safety of all parties directly involved • access rights to any children • potential risk of reoffending	11.9.5
	Bail & risk	Questions of whether bail should be granted or not, should take into account the possibility of repetition of the offense or the likelihood of further offenses being committed by the defendant released	11.9.6
	Safety & protection orders	Circumstances indicate that it may be appropriate to bail the offender, consideration should be given to the safety of the victim and assistance provided to the victim should a protection order be sought	11.9.9
RSIPF SOPs Investigation 2013	High priority FV Cases	All communications officer/dispatchers shall assign a high priority to all family violence	Pages 51-52
	High risk & investigations	All members of the investigations unit involved in high-risk arrests and high-risk investigations must carry the maximum use of force options available to them including at least baton and handcuffs. Communication equipment is also to be carried. The assistance of the police response team is to be considered depending on the circumstances	Pages 51-52
	Risk assessment for High risk cases	Before the commencement of any planned high risk arrest or high risk investigation a thorough risk assessment is to be considered for authorization by the Dir. investigations.	Pages 51-52
	High-risk definition	An investigation or arrest is to be considered high risk where: • there is a probability of confrontation with the person who is armed or is reasonably suspected to be armed with a firearm or other lethal weapon • the person the subject of investigation or arrest has a prior history of significant violence • the safety of a third party is at risk • there is a high level of security present or hazardous entry likely location where investigators are required to enter	Page 52
MoH NCPG	Safety Plan	Steps for safety planning	Appendix 15

Annex 9: Basic Safety Planning Form

SAFENET 6 Basic Safety Planning Questions		
	Question	**Action**
Identify danger		
1.	What are the warning signs of violence? (explanation of cycle of violence) What actions can you take?	
Safe Place to go		
2.	If you need to leave your place in a hurry, where can you go?	
Planning for children		
3.	Would you go alone or take your children with you?	
Transport		
4.	How will you get there?	
Items to take with you		
5.	Do you need to take any documents, phone number, keys, money, clothes or other things with you? Can you put these things in a safe place with someone, just in case?	
Support of someone close by		
6.	Is there a neighbor you can tell about the violence who can call the police or come with assistance for you if they hear sounds of violence coming from your home?	

Annex 10: Detailed Risk Assessment

RISK ASSESSMENT QUESTIONS IN CLIENT FORM

Risk Assessment Questions in Client Form			
RISK or VULNERABILITY FACTORS	**YES**	**NO**	**Notes**
Victim/ Survivor issues which may increase risk			
Who came with the client?			
Permission to contact?			
Status of bride price?			
Perpetrator location?			
Weapons used in current incident?			
Alcohol / drugs in current incident?			
Frequency of Problem			
Severity of the problem			
Duration of violence (first episode to now)			
Main presenting complaint (i.e. separation /divorce)			
Suicide Risk Assessment			
Violence risk assessment (toward others)			
Violence risk assessment (toward client)			
When was the last time you drank alcohol (marijuana, drugs)? How much and how often?			
Observed problems with thinking			

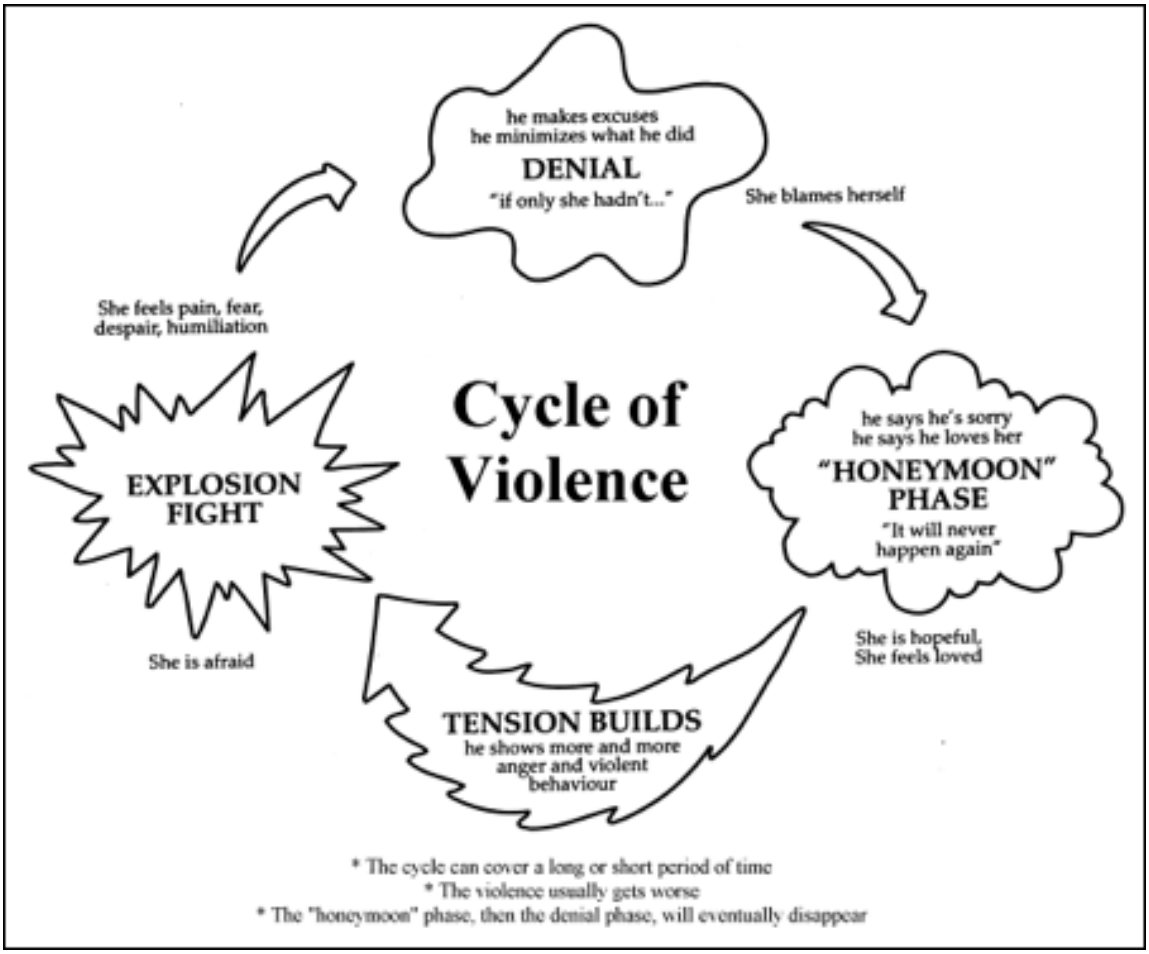
SAFENET In-depth Risk Assessment			
RISK or VULNERABILITY FACTORS	**YES**	**NO**	**Notes**
Victim/ Survivor issues which may increase risk			
Pregnancy / new born baby?			
Did the violence get worse during pregnancy?			
Suffered serious injuries in past week?			
Perpetrator lives in the same house?			
Depression / mental health issues?			
Has ever talked about or had suicidal thoughts or tried to commit suicide?			
Is isolated from family and friends?			

SAFENET In-depth Risk Assessment			
Is fearful of the perpetrator?			(Very fearful or a little fearful?)
Has a safe place to stay?			Where?
Perpetrator issues which may increase risk			
Did the perpetrator use a weapon in most recent event?			
Does the perpetrator have access to weapons? (guns, knives)			
Has ever tried to choke the victim?			
Has ever tried or threatened to kill the victim/survivor?			
From what you might know about the situation do you think that the perpetrator is likely to act on the death threats?			
Has ever harmed or threatened to harm or kill children or family members?			
Has ever threatened or tried to kill himself/herself?			
Has stalked the victim/survivor?			
Has jealous and controlling behavior toward victim/survivor?			
Has sexually assault the victim/survivor?			
Has depression/mental health issues?			
Drug and/or alcohol/kava misuse/abuse?			
Unemployed?			
Has the perpetrator been to prison?			
Does the perpetrator have a history of violent behavior (toward community members, police)?			
Does the perpetrator have a history of family violence?			
Relationship issues which may increase risk			
Is recently separated?			
There has been an escalation / increase in severity and/or frequency of violence			
Has ever interfered with victim/survivor reporting violence?			
Has financial difficulties?			
Victim/survivor assessment of their own safety:			

Case manager / service provider opinion of overall victim/survivor safety		
Is the perpetrator of abuse with victim/survivor now?	☐ Yes	☐ No
Is victim/survivor afraid of the perpetrator?	☐ Yes	☐ No
Is victim/survivor afraid to go home?	☐ Yes	☐ No
Has physical violence increased in severity or frequency?	☐ Yes	☐ No
Has the perpetrator ever physically abused children?	☐ Yes	☐ No
Has the perpetrator ever sexually abused children?	☐ Yes	☐ No
Is there a weapon in the home?	☐ Yes	☐ No
Has the perpetrator ever been threatened to kill someone?	☐ Yes	☐ No
Have there been threats of suicide by the victim/survivor?	☐ Yes	☐ No
Have there been threats of suicide by the perpetrator?	☐ Yes	☐ No

Annex 11: Case Manager Safety Planning Form

Safety Planning		Steps to take:
Identifying Danger	What are the warning signs? When do you take action? (Cycle of Violence)	
Safe Place to go	If you need to leave your home in a hurry, where could you go?	
Planning for Children	Would you go alone or take your children with you?	
Transport	How will you get there?	
Items to take with you	Do you need to take any documents, phone numbers, keys, money, clothes, or other things with you when you leave?	
	Can you put together items in a safe place or leave them with someone, just in case?	
Financial	Do you have access to money if you need to leave? Where is it kept? Can you get it in an emergency?	
Support of someone close by	Is there a neighbor you can tell about the violence who can call the police or come with assistance for you if they hear sounds of violence coming from your home?	


Cycle of Violence
he makes excuses
he minimizes what he did
DENIAL
"if only she hadn't..."
She blames herself
he says he's sorry
he says he loves her
"HONEYMOON" PHASE
"It will never happen again"
She is hopeful,
She feels loved
TENSION BUILDS
he shows more and more anger and violent behaviour
She is afraid
EXPLOSION FIGHT
She feels pain, fear, despair, humiliation
* The cycle can cover a long or short period of time
* The violence usually gets worse
* The "honeymoon" phase, then the denial phase, will eventually disappear

Annex 12: Additional Tips for Safety Planning

Tips for Safety Planning

A Safety Plan focuses on the things you can do in advance to be better prepared in case you have to leave an abusive situation very quickly.

- Create a telephone list with numbers of local police, Family Support Centre (FSC), the local shelter CCC, the 24 hotline (132) crisis help line, family members, trusted friends, counselors (FSC, CCC, IMHS)
- Contact your local police service, GBV Services (999) or a local shelter (CCC). Let the staff know that you intend to leave an abusive situation and ask for support in safety planning.
- When talking to police, ask for an officer who specializes in FV or sexual assault cases (information shared with the police may result in charges being laid against the abuser).
- Request a police escort or ask a friend, neighbor or family member to accompany you when you leave.
- Do not tell your partner you are leaving. Leave quickly.
- If you are injured, go to a doctor at National Referral Hospital (NRH) in Honiara, an accident and emergency (A&E) room or a local health clinic and report what happened to you. Ask them to document your visit.
- Have a back-up plan if your partner finds out where you are going.
- Consult a lawyer at (FSC or PSO). Keep any evidence of physical abuse, such as photos from your phone. Keep a journal of all violent incidents, noting dates, events, threats and any witnesses.

The following is a list of items you should try to set aside and hide in a safe place (i.e. at a friend's or family member's home, with your lawyer).

Take a photocopy of the following items and store in a safe place, away from the originals. Hide the originals someplace else, if you can.

- Medications, prescriptions, medical records for all family members
- Divorce papers, custody documentation, court orders, protection order, Police Safety Notice, marriage certificate
- Lease/rent agreement, house deed, mortgage payment book
- Bank books
- Picture of spouse/partner
- Health cards for yourself and family members
- All cards you normally use i.e. bank cards, phone
  Try to keep all the cards you normally use in your wallet:
- Phone cards
- Bank cards / books
- Health cards / books

Try to keep your wallet/purse handy, and containing the following:

- Car/house/office keys
- Bank books/statements
- Driver's license, registration, insurance
- Address/telephone book
- Picture of spouse/partner
- Emergency money (in cash) hidden away

Things you can do:

- Open a bank account in your own name and keep the information private
- Save and set aside as much money as you can – out of food budget if necessary
- Set aside, in a place you can get to quickly, $10 to $15 for taxi fare and for top up for mobile
- Plan your emergency exits. Think about safe areas of the house where there are no weapons and where there are at least two ways to escape.
- Plan and rehearse the steps you will take if you have to leave quickly, and learn them well
- Decide and plan for where you will go if you have to leave home even if you don't think you will need to
- If the situation is very dangerous, use your own instinct and judgment to keep yourself safe. Call the police as soon as it is safe to do so.
- Hide extra clothing, house keys, car keys, money, etc. at a friend's house
- Keep an emergency bag packed or handy/ready to pack quickly

Creating a Safer Environment

There are many things you can do to increase your safety. It may not be possible to do everything at once. But safety measures can be added step by step. Here are a few suggestions:

At Home:

(a) If you ARE living with your abusive partner/spouse:

- Tell someone you trust about the abuse
- Tell your children that it is never right, even when someone they love is being abusive. Tell them the abuse isn't your fault or their fault; they did not cause it, and neither did you. Teach them it is important to keep safe when there is abuse.
- Make sure all weapons are locked safely away or are removed from your home
- Make arrangements with friends or family so that you can stay with them if necessary
- Try to predict the next likely violent episode and make plans for the children to be sent to friends, family, etc.
- Think about your partner's use and level of force. This will help you predict what type of danger you and your children are facing and when to leave.
- Don't wear scarves or long jewelry as they could be used to assist in strangulation
- Teach the children to let you know when someone is at the door, before answering the door
- Teach your children how to use the telephone (and your cellular phone, if you have one) to contact the police
- Create a code word with your children and/or friends so they know to call for help
- Plan your emergency exits, teach your children and know them well
- Don't run to a place where the children are as your partner may hurt them as well
- Teach your children their own Safety Plan
- Identify a neighbor you can tell about the violence and ask that they call the police if they hear a disturbance coming from your home

If you ARE NOT living with your abusive partner/ spouse:

- If you are comfortable doing so, contact the police and ask them to assist you in staying safe by accompanying you when you return to the home to collect your personal belongings. If you are not comfortable involving the police, request that someone else accompany you.
- Attempt to find housing (even if temporary) that has adequate security: in a location that cannot be easily accessed from the street, with doors with locks, locked front entranceway, etc.
- Consider living with someone else or in a shelter for a short time.
- If you are staying in your home, change the locks on doors.
- Install security measures such as additional locks, window bars, poles to wedge against doors, etc. Placing barriers under door handles can increase security.
- If your partner follows you, go to a place where there are people.
- If you live in the same neighborhood as your ex, or hang out with the same group of people, tell the people whom you trust that you have left the relationship due to safety concerns. Tell them what you want them to do if they see your ex approach you. Don't be ashamed to ask for help or support. Your ex may be less likely to intimidate, threaten or abuse you in the presence of others. Refuse to be alone with your ex.
- Change your schedule. Don't travel the same route each day. Change your appointment times, stay at a different shelter, or request that your services be transferred to another office.
- Inform any service providers that you have left a violent relationship and provide a description of your ex.
- Teach your children how to call 9-9-9 and how to make a call to you and to a trusted family member or friend, in the event of any emergency.
- Tell people who take care of your children (including their school), which people have permission to pick up the children. If you have a protection order, give a copy of it to the people who care for your children
- Inform your neighbours that your ex-partner no longer lives with you and ask them to call the police if they see him or her.
- Keep a copy of any protection orders with you at all times. If you call the police to enforce it, they will ask to see a copy.
- Inform necessary people that you have a protection order, i.e. friends, children's schools, childcare.

In the Neighbourhood

- Tell your neighbours that you would like them to call the police if they hear a fight or screaming in your home
- Tell people who take care of your children which people have permission to pick up your children
- Tell people in your neighbourhood that your partner no longer lives with you, and they should call the police if he/ she is seen near your home. You may wish to give them a photo and description of him/her and of the vehicle they drive.
- Ask your neighbours to look after your children in an emergency
- Hide clothing and your Emergency Escape Plan items at a neighbour's house
- Use different stores / markets for food shopping and shop at hours that are different from when you were living with your abusive partner
- Use a different bank or branch, and take care of your banking at hours different from those you used with your abusive partner.

At Work

- You must decide for yourself if, and/or when you will tell others that your partner is abusive and that you may be at risk. Friends, family and co-workers may be able to help protect you. However, you should consider carefully which people to ask for help. If you are comfortable, you may choose to do any or all of the following:
- Tell your boss, the security supervisor, and other key people or friends at work about your situation.
- Ask to have your calls screened at work. It would also help to have these calls documented.
- Discuss the possibility of having your employer call the police if you are in danger from your (ex) partner.

Annex 13: SAFENET Permission to Share/Exchange Information Form

Permission to Share/Exchange Information

SAFENET Organization _____

Staff Number: _____

Position: _____ Date: _____

Client Number: _____

Information is being shared with and/or released to:

Staff Number: _____

Agency: _____

Relationship to the client: _____

Information to be shared: _____

_____

I agree to allow (staff number)_____ to share the above Information related to my situation in order to advocate/assist me.

_____

Client signature

(This permission can be revoked at any time and will expire after 3 months)

Annex 14: SAFENET Informed Consent Sample Wording

Component	Sample wording
Introduction	Welcome! My name is _____ and I am a case manager with SAFENET Kaban. I would like to tell you about our program so you can decide if you think it might help you and your situation.
What is SAFENET Kaban	SAFENET is a group of organizations that work together to help survivors of sexual or family violence. SAFENET includes: medical services, counseling, emergency shelter, legal advice, police and protection. I am a case manager for SAFENET Kaban, and my office is at the Family Support Center.
Goal/purpose of Case Management Services	The goal of our services is to support you get the help you need so that you can live your life free from violence. We are here so that you don't have to carry these problems all alone.
Role/job of case manager (What can they expect from you? What will you do?)	My job is NOT to give you advice or tell you what to do. My job is to find out what you need and want and help you get there. I will give you information about your rights and the services that are available to you so that you can make choices that are good for you and your family.
Risks	Sometimes making changes to be safe and healthy may not be easy. Sometimes these things are hard to talk about because the problem has been a secret heavy inside you for a long time or you might be afraid to tell your story. Sometimes family members may not understand why you need to come and may pressure you or ask you too many questions.
Benefits	But even if it is difficult, those that participate in our Kaban often feel more confident to make good decisions/choices and they always have someone to talk to even if it takes a long time to solve the problems.
Confidentiality	I will always talk to you privately and keep your file in a locked cabinet. I will always get your permission to share anything you say to me outside of the FSC. I work with a team and a supervisor who assists me to do the best job for clients. It is your choice what we share or keep private. The only exception to privacy is if you tell me that you or someone is in immediate danger, then I may not be able to keep that private because I want you to be safe, but I will discuss this with you first.
What will happen (Meet how often, when, length of session, when is it over)	If you agree and would like our services, then today we will meet for about an hour so I can hear your story. I will get some information from you, and explain what your rights and options are. We will make an Action Plan for safety and other things you might need. Together we will decide how often we will meet and if you would like me to go with you to get some things done to improve your situation. We also have an after-hours phone number I will give you in case there is an emergency and it can't wait. It is your choice. You can change your mind and stop at any time. If you decide to stop or leave, please let us know so that we have a chance to say "good-bye" and to close your file. But you are welcome to return any time you want and start services again. You are always welcome.
Consent Obtained (written or verbal)	Do you have any questions about our services? Would you like to meet with us today and begin?

Annex 15: SAFENET Client Consent Form

FSC/SAFNET CASE MANAGEMENT CLIENT CONSENT FORM

SAFENET SERVICE PROVIDER / CASE MANAGER

SAFENET

Name: _____

Phone Contact: _____

RECIPIENT NAME

My Counselor/case manager has clearly explained the services being offered to me today.

She has explained that:

- Participation is voluntary
- i can change my mind, and stop services whenever i want.
- I can agree to all or part of the services.
- everything i say is confidential and the case manager needs my permission to share any information with other agencies or people unless there is immediate life-threatening danger.
- I have a right to ask questions if i do not understand.
- even if i decline or stop services, i am welcome to return in the future.

I understand what is being offered and have received answers to all of my questions.

I agree to receive and participate in FSC services.

_____ _____

Client Signature Date

_____ _____

Witness Signature Date

Annex 16: SAFENET Case Management Client Intake Forms

SAFENET CASE MANAGEMENT: CLIENT FILE

Date of First Visit:	**Client number (+ Case Manager Code):**

A. CLIENT INFORMATION

Name:	**Who came with client?:**	**Permission to Contact:** ☐ No ☐ Yes – how? _____
Home Address/location:	**Phone number:** #1 _____ #2_____	**Informed Consent:** ☐ About SAFENET/purpose/goal ☐ Role of Case Manager ☐ Benefits/risks ☐ Confidentiality explained ☐ Explain what will happen Consent given: ☐ yes ☐ no
Age: (in full years)	**School/education level:**	

Province From:	From	**REFERRED**	**To**	**Marital Status/how long?:**
	1. ☐	1. SWD	1. ☐	
	2. ☐	2. NRH or HC	2. ☐	☐ Single-never married
	3. ☐	3. Police	3. ☐	☐ Married:_____
	4. ☐	4. Public Solicitor's	4. ☐	☐ live-in partner/defacto marriage:__
	5. ☐	5. CCC	5. ☐	☐ Divorced:_____
	6. ☐	6. Seif Ples	6. ☐	☐ Widowed:_____
	7. ☐	7. Mental Health	7. ☐	☐ Partner missing/left:_____
	8. ☐	8. Family, friends	8. ☐	☐ Arranged Marriage:_____
	9. ☐	9. IEC, outreach	9. ☐	
	10. ☐	10. FSC	10. ☐	Status of Bride Price:
	11. ☐	11. other: _____	11. ☐	
Current Province:				
Sex: ☐ Male (M) ☐ Female (F)				

B. SOCIAL SITUATION:

C. MAIN PRESENTING COMPLAINT/PROBLEM

<table>
<tr><td colspan="2">Presenting Problem: What is the client's story? Why did they come for help now? From the client's perspective, what is the main problem?</td></tr>
<tr><td>Current Incident:
Date/time: _____Location: _____
Perpetrator name:_____ age:_____ relationship: _____
Weapon/object used:_____Alcohol/drugs:_____</td><td rowspan="3">Main presenting complaint code:
1. Physical Abuse (IPV/child)
2. Sexual Abuse/assault
3. Trafficking/exploitation
4. Family conflict
5. Economic/property abuse
6. Child Abduction/reunification
7. Child Neglect/abandonment
8. Divorce/Separation
9. Maintenance/custody
10. Witnessing abuse/violence
11. Other family issues: _____
12. Mental Health conditions (e.g. depression, anxiety, trauma)</td></tr>
<tr><td>Frequency of Problem (how often does it happen?) and duration (how long does the incident go on?)</td></tr>
<tr><td>Severity of the problem (Does the problem cause other problems?)</td></tr>
</table>

D. HISTORY OF PROBLEM

How did the problem begin? First Episode? Worst Episode? Where does it happen?

Client Number: _____

E. GENERAL CHECK-UP:

IF IT IS OKAY, I WOULD LIKE TO ASK YOU A FEW QUESTIONS THAT WE ASK EVERYONE TO MAKE SURE THAT YOU ARE OKAY.

Suicide Risk Assessment **History**: In the past when facing problems have you ever had a time when you thought of harming yourself or committing suicide? **Current**: Are you having any thoughts of hurting yourself right now?	**YES** **NO** **YES** **NO**	**YES:** If either question is answered "yes," then immediately get the assistance of the lead counselor on duty. **NO:** If both questions are answered "no" then continue with intake unless you still have concerns based on other statements or behavior, then get the assistance of lead counselor on duty.
Violence Risk Assessment **Violence Towards others:** **History:** In the past when facing problems have you ever had a time when you thought of hurting someone else? **Current:** Do you currently have any thoughts of hurting someone else?	**YES** **NO** **YES** **NO**	**Same as above.**
Violence Towards Client: Are you in any danger when you leave today?	**YES** **NO**	Reassure client that you will discuss a Safety Plan before they leave. Let client know that we want them to be prepared if it happens again, so we will make a Safety Plan for the future.
Have you ever had a time that you thought that you were going crazy?		
Do you have any other health conditions or disabilities?		
Are you currently taking any Medications or kastom medicine?		
When was the last time you drank alcohol (marijuana, drugs)? How much and how often?		
Observed problems with thinking (slow, poor memory, etc)		
Other Observations (appearance, hygiene, mood, anxious, vigilance, behavior, speech, eye contact, etc)		

Client Number: _____

Client Coping Strategies

1. What has the client already tried to help the problem (example: police, traditional healers, mediation, religious leaders consulted, use of alcohol/drugs, distraction)?

2. What are the client's strengths?

3. According to the client, what are some possible solutions for the problem?

4. Identify client's social support network (family, friends, neighbors, etc.)

SAFENET Action Plan

Client's Decision

Reviewed Rights and options (circle)	Area requiring an Action Plan	No Need	Yes	Later	Not Sure	No
Yes	**Personal/Family Safety Plan**					
Yes	**Medical**					
Yes	**Shelter**					
Yes	**Emergency practical needs**					
Yes	**Police Safety Notice (FPA)**					
Yes	**Legal Justice**					
Yes	**Psychosocial**					
Yes	**Other:**					

GOAL #1: Safety				
Practical Steps to be taken:	**Date Set**	**Who will do it?**	**When**	**Date Completed or changed**
1.				
2.				

GOAL #2:				
Practical Steps to be taken:	Date Set	Who will do it?	When	Date Completed or changed
1.				
2.				

GOAL #3:				
Practical Steps to be taken:	**Date Set**	**Who will do it?**	**When**	**Date Completed or changed**
1.				
2.				

GOAL #4:				
Practical Steps to be taken:	**Date Set**	**Who will do it?**	**When**	**Date Completed or changed**
1.				
2.				

GOAL #5:				
Practical Steps to be taken:	**Date Set**	**Who will do it?**	**When**	**Date Completed or changed**
1.				
2.				

Case Manager's Signature: _____

First Follow-up Appt scheduled for: _____

CLOSING FILE:

Total Number of Review Sessions:	**Number of times accompanied:**	**Date File Closed:**
Main Presenting Complaint- status at last visit ☐ 1. Completely resolved ☐ 2. Mostly resolved ☐ 3. Decreased ☐ 4. At same level ☐ 5. Increased in severity		Client's goals met: ☐ 1. all goals met, ☐ 2. much progress, ☐ 3. some progress, ☐ 4. little progress, ☐ 5. no progress
Type of Exit ☐ 1. Services/Support Completed ☐ 2. Drop out: unable to trace/no reason ☐ 3. Drop out: Different expectation/only information needed ☐ 4. Drop out: Dissatisfied with the service ☐ 5. Drop out: Client reports feeling better ☐ 6. Relocated or lives too far away		

Case Notes: **Client Number:** _____

Date:	Time used Hours: Minutes:	Type of Service: ☐ Intake Assessment/Action Plan ☐ Action Plan review ☐ Accompaniment ☐ Community Networking ☐ SafeNet Case Conference ☐ Other: _____
Location (circle one): Phone FSC Seif Ples Police PSO SOS Clinic NRH Client's Home CCC Church Other: _____		
Person's Present/Involved/Contacted:		
Intervention (Activity; What did you do?):		
Response to Intervention:		
Plan (next step):		Case Manager's Signature:

Annex 17: Case Manager Weekly Workload

WEEKLY WORK PLAN AND TOTALS

Name: _____

Day/date	**New Client** (use client number only)	**Follow up Client** (use client number only)		**Total Number of sessions**	**Closed client files**
		Scheduled	**Show** Yes/no		
Monday Date: _____					
Tuesday Date: _____					
Wednesday Date: _____					
Thursday Date: _____					
Friday Date: _____					
Weekend: Date: _____					
Totals for week	Total New Clients:	# Follow ups Scheduled	# No-shows # Shows	Total number of sessions	Total Files closed

Annex 18: Data Summary Sheet

FSC Client File **Client Number (plus Counselor and/or CM code): _____**

Date of Opening (or reopening): _____

Case Management Opening File DATA

Age: (in full years)	From:	REFERRED	To:	Main presenting complaint code:
				☐ 1. Physical Abuse (IPV/child)
	1.	1. SWD	1.	☐ 2. Sexual Abuse/assault
Province From:	2.	2. NRH or HC	2.	☐ 3. Trafficking/exploitation
	3.	3. Police	3.	☐ 4. Family conflict
	4.	4. Public Solicitor's	4.	☐ 5. Economic/property abuse
	5.	5. CCC	5.	☐ 6. Child Abduction/reunification
Current Province:	6.	6. Seif Ples	6.	☐ 7. Child Neglect/abandonment
	7.	7. Mental Health	7.	☐ 8. Divorce/Separation
	8.	8. Family, friends	8.	☐ 9. Maintenance/custody
	9.	9. IEC, outreach	9.	☐ 10. Witnessing abuse/violence
Sex:	10.	10. FSC	10.	☐ 11. Other family issues:
Male (M)	11.	11. Other:_____	11.	_____
Female (F)				☐ 12. Mental Health conditions (e.g. depression, anxiety, trauma)

Type of Service: ☐ Case Management ☐ Counseling ☐ Group ☐ Legal	Opening Data Entered Date: Initials:

Case Management Closing File Data:	**Staff Number:**	
Total Number of Review Sessions:	**Total Number of times Accompanied:**	**Date File Closed:** **Main Presenting Complaint-status at last visit:** ☐ **1. Completely resolved** ☐ **2. Mostly resolved** ☐ **3. Decreased** ☐ **4. At same level** ☐ **5. Increased in severity**
Client's goals met: ☐ **1. all goals met,** ☐ **2. much progress,** ☐ **3. some progress,** ☐ **4. little progress,** ☐ **5. no progress**	**Type of Exit:** ☐ **1. Services Competed** ☐ **2. Drop out: unable to trace/no reason** ☐ **3. Drop out: Different expectation/only information needed** ☐ **4. Drop out: Dissatisfied with the service** ☐ **5. Drop out: Client reports feeling better** ☐ **6. Relocated or lives too far away**	

Counseling DATA	**Staff Number**	
Open Date:	**Close Date:**	**Total # Sessions:**
Complaint Rating at FIRST visit: 1 2 3 4 5 6 7 8 9 10 Best Worst	**Focus of Counselor's Intervention:** ☐ 1. Inner Problems ☐ 2. Lack of Skills ☐ 3. Overwhelming Feelings ☐ 4. Practical problems ☐ 5. Trauma-related symptoms ☐ 6. Psychiatric support	**Complaint Rating at LAST visit:** 1 2 3 4 5 6 7 8 9 10 Best Worst
Functional Rating at FIRST visit: 1 2 3 4 5 6 7 8 9 10 Best Worst		**Functional Rating at LAST visit:** 1 2 3 4 5 6 7 8 9 10 Best Worst

Staff Number:			
Legal Service Opening Date:		**Date Legal file closed:**	
Type of Case: ☐ Maintenance ☐ Divorce ☐ Other: _____	☐ Protection ☐ Custody	Closing Type: ☐ Legal Information/advice only ☐ Case filed but dropped out ☐ Court order issued	Total # consultations: Total # court appearances:

Closing DATA Entered

Date: Initials:

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