



# **GUIDELINES FOR THE OPERATION OF CARE FACILITIES FOR VICTIMS OF TRAFFICKING AND VIOLENCE AGAINST WOMEN AND GIRLS**

**RATIONALE, BASIC PROCEDURES AND  
REQUIREMENTS FOR CAPACITY BUILDING**

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## INTRODUCTION

### 1. Purpose

This document outlines the rationale (designated 'Rationale') and basic procedures (designated 'Actions') undertaken by facilities that provide care for adolescent and adult victims of trafficking and violence against women and girls. These procedures/actions are based on international minimum standards and guidelines for the operation of care facilities.

As this document is intended for use in the capacity-building of care facilities, the document also indicates the policy, guidelines, training, personnel and material requirements (designated 'Requirements') to accomplish those actions.

### 2. Scope

The target group identified for care is female adolescent and adult victims of trafficking, domestic abuse, commercial sexual exploitation, abandonment, rape, armed conflict and other forms of violence against women and girls.

This document covers the basic activities of care with some exceptions: medical care, legal response, care for pre-adolescent children, and care for HIV+ persons. Standard administrative practices (such as financial management) and staff management requirements (such as a general personnel policy) that are routine for all organizations are not included in this document.

### 3. Applications

This document, in whole or part, is applicable to long-term shelters, transit homes, overnight shelters, drop-in centres and crisis centres that provide care for female adolescent and adult victims of trafficking and violence against women and girls.

### 4. Minimum Standards of Care and Human Rights

Nepal does not have a national document for minimum standards of care for facilities that provide support to children or women in need of special protection, or for children without family. For this document, reference to minimum standards has been made to a variety of international standards and guidelines documents. These documents range from broad human rights standards to detailed standards for the operational management for care facilities. (Refer to Annex I: References).

Minimum standards are the foundation of 'rights-based' programming, in that they activate the rights of children encompassed in the UN Convention on the Rights of the Child (UNCRC) and other instruments. With some exceptions, every right of the child in the UNCRC is put into action through the application of basic minimum standards in the caregiving setting. For example: Article 19, protection from abuse and neglect, is ensured through standards which require, among other things, screening and abuse-protection mechanisms in staff management; Article 12, engaging the child's opinion in all matters that affect him/her, is ensured through the requirement for participatory mechanisms in deciding matters of treatment, family reunification, etc.



A reference for key minimum standards is provided in Annex II: Universal Minimum Standards. These are a short compilation of key standards from the documents listed in Annex I. This compilation is neither exhaustive nor detailed, and is intended to provide an overview of the standards upon which this document is based.

It should be noted that where minimum standards of care are in effect, they are formal legal requirements under international, national, state and/or local law. Operation according to minimum standards is a legal obligation of the caregiving facility, and lack of adherence to standards can result in closure of the facility, fines and other legal responses.

## **5. Principles of care**

Basic principles of care, implicit in the operation of facilities according to minimum standards, are as follows:

**The institution as a last resort.** The well-being of women and children is best promoted in the family setting. Should this be unavailable, informal 'family-like' care provided by members of the community (extended family care, foster care) is the next option. Formal residential settings are appropriate only if the former are unavailable or the victim requires formal institutional care for legal, medical or psychological reasons.

**Rapid reintegration.** It is the obligation of the care facility to provide periodic review of placement with the objective of reintegrating the victim into the family or an alternative community setting quickly and effectively. Prolonged institutionalization is discouraged.

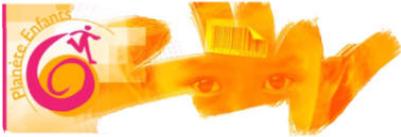
**Consent.** Adults should only be in residential care with their informed consent. Consent should be sought from children placed in residential care, however their consent can be waived by parents, guardians and persons in authority for reasons of their protection and well-being.

**Access to family.** With all protection considerations, all persons, adult and child, have the right to meet and interact with their family, including family members who are in prison or who may have committed abuse.

**Access to appropriate information.** All persons in care have the right to be provided all information about their situation, identity, family and medical condition, among others. Denial of information is acceptable only for reasons of protection or possible psychological distress.

**Participation in decisions.** All persons in care have the right to express their opinions and participate in decisions on all matters affecting them, including residency, treatment, education and occupational training.

**Association with others.** It is the obligation of the facility to provide all persons in care with access to persons in the surrounding community and the support of peers, and to encourage positive relationships and attachments.



**Healing environment.** The care facility recognizes the need to create a healing social and physical environment. The social environment includes friendly, positive, non-authoritative interaction between residents and staff, adequate time and opportunity for recreational activities, and access to friends and family. The physical environment includes provision of a personalized space for residents (own bed, private storage of personal belongings, places to personalize their private space with their own belongings such as photographs and mementos), and comfortable, clean 'home-like' surroundings.



## **GUIDELINES FOR THE OPERATION OF CARE FACILITIES FOR VICTIMS OF TRAFFICKING AND VIOLENCE AGAINST WOMEN AND GIRLS**

### **1. GENERAL CONSIDERATIONS**

Caregiving facilities operate under clear policies, and have clear statements of the services that are provided, the population who receive those services, and the length of service provided.

#### **1.1 Policies**

Rationale: The central organization that operates the care facility as well as the designated care facility have clear and simple policies stating the guiding principles, objectives and strategies of operation.

##### Actions

- All staff are oriented in and provided copies of the policies.
- All residents, upon admission, are oriented in and provided copies of these policies.

##### Requirements

- Policies for the central organization are present in written form and are available to both staff and residents.
- Policies for the designated care facility are present in written form and are available to both staff and residents.

#### **1.2 Services provided**

Rationale: The central organization identifies the services provided and not provided by the specific care facility, and the facility operates within those parameters. Victims accessing the care facility who require services not provided by the facility are referred to other appropriate facilities. Note: No care facility should attempt to provide care for which its staff are not fully trained and the facility is not equipped. Examples of conditions for which a facility may not be able to provide care include:

- severe psychological problems
- mental disability
- physical disability
- pregnancy
- HIV/AIDS and/or STDs
- Tuberculosis
- severe discipline problems

##### Actions

- Persons are provided services for which the facility is trained and equipped, and persons who require other services are referred to other facilities or organizations.

##### Requirements

- The central organization identifies which services can and cannot be provided by the care facility.
- A description of services provided by the care facility are present in written form and are available to both staff and residents.



- Designated staff are adequately trained in, or on-call persons are available to provide, the services identified by the care facility.
- The facility is adequately equipped to provide identified services.
- Appropriate collaboration with organizations, hospitals, etc. that provide services not provided by the care facility is established, and a referral system is present (see 'Case Management: Referral to other facilities' below).

### **1.3 Target group**

Rationale: The care facility has clear indications of the target group for whom it will provide services. This assists the facility in providing adequate support and referral, and prevents the residence of inappropriate persons in the facility. Among other criteria, the target group is identified according to sex, age, nationality and reason for residence in facility (such as poverty, orphan, domestic violence, trafficking, etc.). Note: The facility should make careful criteria, considering such questions as: Is poverty alone a sufficient reason for admission? Should a 12-year-old male child who accompanies an abused woman be admitted? Should a victim of domestic violence who is an Indian national be admitted?

#### Actions

- Persons within the target group are admitted into the facility, and persons outside the target group are referred to other facilities or organizations.

#### Requirements

- A description of the target group serviced by the care facility is present.
- Appropriate collaboration with organizations that provide services to persons not identified as the target group is present.

### **1.4 Length of service provided**

Rationale: The care facility has clear indications of the length of service to be provided to residents. A 'transit home' generally provides short-term residence (up to one month), a 'shelter' usually provides short- to medium-term residence (up to 6-12 months), while other facilities such as orphanages or homes for the disabled may provide long-term or even permanent residence.

#### Actions

- Persons who require the designated length of service are admitted into the facility, and referral is provided for those who require a longer length of service.

#### Requirements

- A description of length of service provided by the care facility is present.
- Appropriate collaboration with organizations that provide services for persons who require a different length of service is present.

## **2. ADMINISTRATION AND STAFF**

Caregiving facilities that provide care to persons who are sexually abused, trafficked, HIV-positive, suffering from psychological disturbances, or in danger of self-harm or suicide require a rigorous level of professionalism, training and administration. Note: Standard administrative practices (such as financial management) and staff management requirements (such as a general personnel policy) that are routine for all organizations are not included in this document.



## **2.1 Administration of the peripheral care facility by the central organization**

**Rationale:** To ensure appropriate care, the lines of administration of care facilities are clearly defined. The central organization has a clear delineation of the tasks/responsibilities of central management vis-à-vis peripheral facility management, including hiring and supervision of staff, monitoring of activities, provision of reports, purchasing, and financial administration.

### **Actions**

- The administrative and managerial relationship between the central organization and the peripheral care facility is clarified and documented.
- Senior staff of the central organization and the peripheral care facility are oriented in this relationship.

### **Requirements**

- A description of the administrative and managerial relationship between the central organization and the peripheral care facility is present in written form and is available to senior staff of the central organization and the care facility.

## **2.2 Job descriptions, training standards and competencies of staff**

**Rationale:** Certain aspects of caregiving for sexually abused, trafficked or HIV-positive persons require professional training. Job titles such as ‘Counselor’ or ‘Social Worker’ are only applied to persons professionally trained as such. Activities such as counseling for trauma or attempted suicide, if conducted by an untrained or inexperienced person, can possibly result in re-traumatization or other harm to the victim, and can only be conducted by a professional counselor, psychologist or psychiatrist with adequate clinical training. Other activities, such as family assessment, can only be conducted by a professional social worker or a person adequately trained in para-social work. **Note:** In both counseling and social work, ‘training’ implies supervised clinical practice as well as theoretical study. Those with university degrees who lack clinical training are not considered adequately trained to conduct counseling for severe trauma or attempted suicide.

### **Actions**

- All staff understand and work according to their roles, responsibilities and lines of supervision.
- Activities are conducted only by appropriately trained and qualified staff.

### **Requirements**

- Appropriate job titles, written job descriptions, and documents describing roles, responsibilities, lines of supervision, and qualifications for all staff positions are present.
- A training standards/competencies document for all positions working directly with victims is present.
- All new staff and existing staff are provided with job descriptions, and documents indicating responsibilities, lines of supervision, and qualifications.
- Existing staff working directly with victims who do not meet designated qualifications and/or training standards and competencies are either trained to the adequate level or are replaced.
- New staff are hired according to qualifications and training standards and competencies.

## **2.3 Staff training (general)**



**Rationale:** Apart from professional training (counseling, social work) and training for specific tasks (life skills teaching, first aid, therapeutic crisis intervention, etc.) certain kinds of 'general training' are provided to all staff in the facility (including drivers, guards and cleaning persons). Other kinds of general training are provided to all staff who work directly with victims. These general trainings provide staff with the basic knowledge and skills required to work with a wide range of victims in general circumstances.

#### Actions

- Designated staff are trained in providing general trainings, or outside trainers are identified.
- Trainings in general subjects are provided to all existing staff who have not received such.
- All new staff receive appropriate general trainings.

#### Requirements

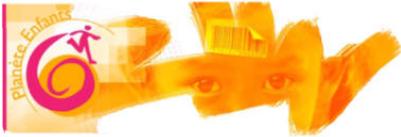
- A list of training requirements for all staff of the facility is present, and includes, among others:
  - children's rights, women's rights and gender issues
  - violence against women and children (trafficking, domestic abuse, child abuse, rape, etc.)
  - confidentiality
  - protection
  - supportive modes of interaction with children, girls and women
- A list of training requirements for all staff who work directly with the residents is present, and includes, among others:
  - adolescent and child development
  - group dynamics
  - basic communication and listening skills
  - anger management and conflict resolution
  - appropriate responses to sexualized behaviors
  - preliminary assessment ('warning signals') of trauma, depression, self-injury or suicidal tendencies, etc.
- Training curricula for these subjects are present.
- Designated staff or outside trainers who are trained in providing these trainings are present.

## **2.4 Staff support mechanisms**

**Rationale:** Working with persons who have been abused, trafficked, etc. is a difficult and stressful occupation. Counselors and all staff who work directly with victims need special support both to maintain their mental health and to conduct their work effectively. For staff who work directly with victims, working in a care facility frequently requires unforeseen time and commitment beyond their job descriptions. Consequently, it is necessary to provide adequate numbers of staff at all times to avoid 'overload', and to provide all staff with means to discuss their personal concerns.

#### Actions

- Staff have workloads commensurate with their contracts.
- All staff working directly with victims are provided with care-for-caregivers support.
- Staff have a means to voice complaints and problems to management through a person independent of line management.



### Requirements

- Counseling and care-for-caregivers activities for staff working directly with victims are present.
- The workloads of all staff are assessed, tasks are reassigned and additional staff are hired, if necessary, to make an appropriate staff-to-resident ratio and to ensure that the workloads of all staff are realistic and equitable.
- A complaint and problems reporting system is present, and staff members independent of line management are identified to respond to the personal concerns of staff members.

## **3. CONFIDENTIALITY AND PRIVACY**

Rationale: Victims of domestic abuse, sexual violence or commercial sexual exploitation can face severe problems of stigma, discrimination, social rejection and violence if their situation is indiscriminately revealed to the family and community. In addition, victims' psychological or social problems can be aggravated if their personal experiences are shared or publicly displayed. Consequently, absolute confidentiality regarding victims' identities, past experiences and present concerns is imperative in a care facility. In a communal environment like a care facility, measures to ensure privacy are necessary to maintain victims' sense of self-autonomy and well-being, as well as to protect the confidentiality of their private concerns.

### Actions

- Confidentiality about the identities, past experiences and present concerns of victims is protected and maintained.
- Residents are afforded privacy for personal matters.

### Requirements

- A policy on confidentiality and privacy is present, and includes:
  - access to case records and other personal records.
  - release of information and what information is provided to others (including central office, doctors, lawyers, police, media, etc.)
  - observation of victims by outside persons, including interviews and photographs
  - publication of victim's case history or photographs
  - use of victims in presentations, seminars and publicity events
  - entry without permission into 'private space' and access to victim's personal belongings
  - privacy for personal matters, including bathing and hygiene
  - privacy for interpersonal matters, such as discussions with family and friends
  - disciplinary measures for staff for breaches of confidentiality and privacy
- Guidelines on procedures to ensure confidentiality and privacy are present.
- Certain staff are designated for access to information, and access is restricted to others (both on paper and computer)
- Physical mechanisms to restrict access are present (locked cabinets, computer files restricted by passwords, etc.)
- All staff (including guards, cooks, etc.) are trained on the policy and guidelines for confidentiality and privacy, including disciplinary measures for breaches of same.
- Residents are oriented on the policy for confidentiality and privacy.



#### 4. PROTECTION

Rationale: While individuals in care, particularly victims of domestic abuse, sexual violence or commercial sexual exploitation, may have personal protection concerns (addressed in Assessment and Case Management below), all persons in care require adequate protection from four possible sources of harm:

- staff or residents within the facility
- self, including self-negligence, drug overdose, self-harm or suicide
- persons outside the facility
- natural events, including electrocution, fire, earthquake, etc.

Actions:

- All residents and staff are protected from harm 24 hours a day, 7 days a week.

Requirements

- A protection policy is present.
- All staff (including guards, cooks, etc.) are oriented on the protection policy.
- Procedures for protection are present, and include:
  - protection of residents from sexual or physical abuse by staff or residents, including:
    - screening mechanisms for hiring of staff
    - a monitoring system to identify abuse of residents by staff
    - procedures for staff reporting of abuse
    - a complaint system for residents reporting of abuse
  - response to self-harm
  - response to risk from persons outside the facility
  - response to natural events
  - response to absence without authority (running away)
  - notification of authorities in case of significant events (death, staff misconduct, serious illness/injury, drug abuse, violence, etc.)
- All staff (including guards, cooks, etc.) have received training in the following:
  - child protection and child sexual abuse
  - procedures regarding abuse by staff
  - general procedures for emergency situations
- All managerial staff and those who work directly with residents have received training in the following:
  - all protection procedures
- first aid, therapeutic crisis intervention, emotional crisis management, and drug abuse management.
- One or more persons trained in the above are present in the facility 24 hours, 7 days a week.
- Contacts for assistance for emergencies (police, hospital, fire, etc.) are present and posted.
- Equipment and materials for emergencies (medical kit, fire extinguishers, etc.) are present and readily available.

#### 5. FIRST RESPONSE



Victims of domestic violence, victims of rape and physical violence from the community, victims of armed conflict, and/or girls/women who have been intercepted during trafficking may arrive at the facility with urgent physical, protection, medical or psychological needs. The facility has the ability to provide immediate response to those needs.

### **5.1 Response to immediate physical needs (food, shelter, comfort)**

**Rationale:** The victim may arrive at the facility frightened, confused, hungry, cold, etc.

#### **Actions**

- The victim is provided with a short, clear 'Immediate-response' orientation, including assurance of safety/protection, explanation of the purpose of the facility, and request for basic information about the victim, her needs, and her situation.
- The victim is placed in a stabilizing friendly environment and provided with food, clothing and physical comfort.
- A designated staff person or peer is continually present to support the victim.

#### **Requirements**

- Guidelines for immediate response to physical needs are present.
- Qualified staff are trained in the activities described in those guidelines.
  - appropriate response
  - interviewing skills
- Designated staff are present or on call 24 hours a day, 7 days a week (On call system).

### **5.2 Protection response**

**Rationale:** The victim may arrive at the facility in danger from an outsider (husband, trafficker, rapist), at risk of harming herself, or with children at risk (from husband, etc.).

#### **Actions**

- The victim is interviewed regarding possible harm to self or children from outsiders.
- The victim is assessed regarding possible self-harm or suicide.
- Steps are taken to protect the victim.
- If necessary, outside support (police, guards) is enlisted.
- A designated staff person or peer is continually present to support the victim.

#### **Requirements**

- Guidelines for immediate protection response are present.
- Qualified staff are trained in the activities described in those guidelines, which include:
  - appropriate response
  - personal protection skills (self-defense)
  - Therapeutic Crisis Intervention
  - self-harm and suicide prevention training
- A contact system with local police and other protection persons is present.
- The facility has an appropriate security system (guards, gates, etc.)

### **5.3 Medical response**

**Rationale:** The victim may arrive at the facility with physical injuries or other medical needs.



### Actions

- The victim is assessed regarding physical injuries.
- Steps are taken to address physical injuries.
- If necessary, outside support (doctor, nurse) is enlisted.
- A designated staff person or peer is continually present to support the victim.

### Requirements

- Guidelines for immediate medical response are present.
- Qualified staff are trained in the activities described in those guidelines.
  - first aid and emergency care
- A professional medical person (nurse, doctor, EMT) is on call 24 hours a day, 7 days a week.
- A contact system with local hospitals and medical persons is present.
- The facility has appropriate first aid equipment.
- The facility has a designated clinic room.
- A staff person is designated as a Support Person (SIC) and those persons are trained.

## **5.4 Psychological response**

Rationale: The victim may arrive at the facility with severe psychological disturbance.

### Actions

- The victim is assessed regarding severe psychological disturbance.
- Steps are taken to address severe psychological disturbance.
- If necessary, outside support (psychologist, psychiatrist, doctor) is enlisted.
- A designated staff person or peer is continually present to support the victim.

### Requirements

- Guidelines for immediate psychological response are present.
- Qualified staff are trained in the activities described in those guidelines.
  - assessment of severe psychological disturbance
  - basic counseling skills
  - emotional crisis management
  - Critical Incident Stress Debriefing
- A professional person (psychologist, psychiatrist or doctor trained in dealing with psychological emergencies) person is on call 24 hours a day, 7 days a week.
- A contact system with local hospitals, psychiatric wards, etc. is present.
- The facility has a designated room for immediate response cases.

## **5.5 First response reporting form**

Rationale: It is necessary to document all activities of immediate response.

### Actions

- The First Response Form is completed, appropriately filed and provided to others (central office, police, etc.) as deemed necessary.

### Requirements

- An First Response Form is present.
- Staff are trained in the use of the First Response Form.

## **5.6 Police documentation**

Rationale: The facility works in coordination with local police in cases of rape, physical violence, trafficking, etc. In some situations, victims are referred by police to the facility;



in other situations, the facility reports the cases to the police to solicit protection for the victims and/or to initiate legal action against the perpetrator. Often, the victim must present their case before the police at the police station, so that the police can make a First Information Report (FIR) as the first step in intercession.

#### Actions

- The facility makes contact with the police regarding the case.
- Appropriate information is provided to the police by the facility, and referral to the police is documented in the First Response Form.
- Documentation by the facility for the police is provided.
- The police conduct one or more interviews with the victim (usually at the police station).
- A designated staff person is continually present to support the victim.

#### Requirements

- Guidelines for police/facility interaction regarding cases are present.
- Police and designated staff persons are trained in those guidelines.
- As required, a Security Form or other form, requesting police protection, or other forms required by the police are present.

### **5.7 Family contact (first contact)**

Rationale: The victim's family, guardian, friends or other persons (if any) who have responsibility and/or can provide protection and support are contacted as soon as possible. Note: Care is taken that the family, friends, etc. are not the sources of the abuse, trafficking, etc. It is the responsibility of the facility and the police to ensure that the victim is not returned to a situation in which they will be revictimized. If such a situation is identified, legal action is taken to protect the victim and, if necessary, to not allow the victim's reunification with the family.

#### Actions

- Staff contact the family.
- When possible, staff contact police, field workers, etc. ascertain if the victim is at risk of subsequent abuse, trafficking, etc. if she is returned to her family, friends, etc.
- Designated staff interview the family.
- The victim and her family are allowed to discuss their concerns both privately and with support of the staff.
- If the victim is to be reunited with the family, and the victim has no legal or medical concerns, the victim is provided contacts in case of difficulties, abuse, etc.
- If the victim is to be reunited with the family, and the victim has legal or medical concerns, the victim is provided contacts with police, lawyers, doctors, etc. as appropriate.
- If the victim is to stay in the facility, and the victim is a minor, a Residency Agreement Form is signed by the family, victim and staff, and copies provided to all.
- The family contact is recorded.

#### Requirements

- Guidelines for first family contact are present.
  - the guidelines include tools for assessing possible abuse, trafficking, by the family, friends, etc.



- Qualified staff or peers are trained in the activities described in those guidelines.
- A Family Contact Form is present.
- A Residency Agreement Form, by which the family agrees to the residency of a minor in the facility, is present.
- A comfortable, private space is provided for contact between victim and family.

## 6. INTAKE

The process of intake into the facility is conducted carefully and thoroughly as this provides the basis for all subsequent interventions, including legal/police response to the victim's problems, treatment of the victim, and family reunification/reintegration.

### 6.1 Intake interview

Rationale: In order to respond to the victim's needs, appropriately detailed information is collected from the victim. At the same time, the victim's rights to privacy, confidentiality and mental health is taken into consideration.

#### Actions

- The intake interview is conducted as soon as possible with considerations of: a) not retraumatizing the victim; b) collecting adequate and truthful information; c) ensuring privacy and confidentiality of information.

#### Requirements

- Guidelines for conducting the intake interview are present.
- Qualified staff are trained in the activities described in those guidelines.
  - interviewing skills for victims of trafficking, abuse, etc.
  - training in privacy, confidentiality, etc. issues
- An Intake Interview Form is present.
  - history, reason from referral, medical history, previous record
  - demographic data, including information for family tracing
  - information about the alleged maltreatment

### 6.2 Initiating the case management process

Rationale: Each individual in the facility is provided care, protection and reintegration according to a routine case management process. A case file is kept for each resident throughout and following her stay in the facility. As the first step in case management, a case file is opened for the new resident.

#### Actions

- A case file is formally opened for the new resident.
- One staff person, trained in case management, is formally designated as the case manager for that individual resident.

#### Requirements

- Guidelines for case management are present.
- All staff responsible for any aspect of victim's care as well as all out-facility persons involved in their care (doctors, lawyers, psychologists, police, etc.) are trained in case management.
- One or more persons on the staff who are trained in case management are designated case manager(s), and undertake the responsibilities of case management for individual residents.
- All forms required in the case management process are present.



- First response and intake
  - First Response Form
  - Security Form
  - Family Contact Form
  - Residency Agreement Form
  - Intake Interview Form
- Assessment
  - Assessment Summary Form
  - Protection Assessment Form
  - Medical Assessment Form
  - Psychological Assessment Form
  - Social Assessment Form
  - Literacy/skills Assessment Form
  - Participatory Future Plan Assessment Form
  - Family and Community Assessment Form
- Planning
  - Protection Plan Form
  - Treatment Plan Form
  - Reintegration Plan Form
- Referral and discharge
  - Referral Form
  - Discharge Form
- These forms and other information are kept in individual case files.

### **6.3 Orientation to the residents**

Rationale: When entering care by the facility, the victim is provided orientation to help her understand how her needs will be met in the short-term and, if necessary, in the long-term, to inform her of her rights and responsibilities within the facility, and to make her feel comfortable and secure in her new environment.

#### Actions

- The new resident is provided with orientation, by staff, peers or both.
- The new resident is welcomed and introduced to the staff and other residents.
- A peer is designated peer acts as a 'buddy' to assist the person, answer questions, etc. for the first week.

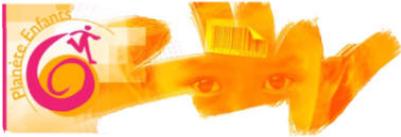
#### Requirements

- Guidelines for intake orientation are present.
- Qualified staff or peers are trained in the activities described in those guidelines.
- Materials for orientation are present
  - policies, rules and regulations of the facility
  - staff personal names, designations and roles
  - a video, illustrated or other orientation presentation

## **7. ASSESSMENT**

### **7.1 Assessment Summary (Problem List)**

Rationale: In the case management process, the assessments are summarized, identifying specific problems and needs of the victim. The Assessment Summary serves as the guidelines for determining treatment and rehabilitation interventions.



### Actions

- As each assessment is completed, specific problems and needs are put in the Assessment Summary Form
- The Assessment Summary Form is placed in the victim's case file

### Requirements

- The Assessment Summary Form is present, and includes:
  - physical health needs
  - psychological needs
  - social needs
  - legal service needs
  - education/skills needs
  - needs related to the victim's plans for the future

## **7.2 Protection assessment**

Rationale: The risks and vulnerabilities (if any) of the victim is assessed, leading to the planning of activities to ensure the protection of the victim and her children (if any). Some victims may have no needs of protection. However, this is only deduced through a protection assessment.

### Actions

- The protection assessment is conducted within 15 days after intake
- The Protection Assessment Form is completed and placed in the victim's case file
- The protection problems/needs (if any) of the victim are recorded in the Assessment Summary

### Requirements

- Guidelines for protection assessment are present.
- A staff person (usually Case Manager or Counselor) is trained in protection assessment and designated to conduct the protection assessment.
- A Protection Assessment Form is present (may be part of a larger Assessment Form)

## **7.3 Medical assessment**

Rationale: The medical needs of the victim are assessed, including dental care. Note: Testing for HIV/AIDS or STIs is only conducted at the request of the victim, and according to international rules of permission, privacy and confidentiality. Note: The medical and dental assessment are only conducted by professional medical doctors or dentists. Note: Medical examinations for females are conducted, if possible, by female doctors.

### Actions

- The victim is provided a full medical examination within 5 days after arriving in the facility.
- If the victim is provided with HIV/AIDS and STI testing, she is provided with appropriate pre- and post-test counseling according to established VCT methods.
- The victim is provided a dental examination within 1 month of arriving in the facility
- The Medical Assessment Form is completed and placed in the victim's case file (and may be kept in the doctor's files if needed)



- The medical problems/needs (if any) of the victim are recorded in the Assessment Summary
- A designated staff person is continually present to support the victim.

#### Requirements

- Appropriate doctors, dentists and medical centres are identified to provide medical assessments
- These doctors, dentists and the contact staff of medical centres are appropriately trained. Training includes:
  - medical assessment (including forensic examination) for abuse/trafficking victims
  - the needs and circumstances of victims of domestic violence, rape, trafficking, etc.
  - permission, privacy, confidentiality, etc. issues
  - case management, as practiced by the facility, including the use of the Medical Assessment Form
  - if HIV/AIDS and STI testing is conducted, either the examiner or other staff of the medical establishment is trained in VCT.
- A Medical Assessment Form is present (may be part of a larger Assessment Form)

### **7.4 Psychological assessment**

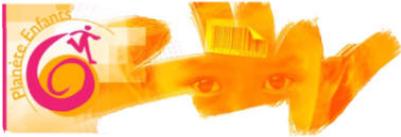
**Rationale:** The psychological health of the victim is assessed, with particular regard for acute depression, PTSD and self-injury/suicidal tendencies. **Note:** The psychological assessment is only conducted by a professional psychologist or psychiatrist. Counseling training is not an adequate qualification to conduct psychological assessment. With adequate additional training, a doctor may be qualified to provide psychological assessment.

#### Actions

- The victim is provided a full psychological examination within 5 days after arriving in the facility.
- The Psychological Assessment Form is completed and placed in the victim's case file (and may be kept in the psychologist/psychiatrist's files if needed).
- The psychological problems/needs (if any) of the victim are recorded in the Assessment Summary.
- A designated staff person is continually present to support the victim.

#### Requirements

- Appropriate psychologists or psychiatrists are identified to provide psychological assessments
- These psychologists/psychiatrists and the contact staff at their facilities are appropriately trained. Training includes:
  - psychological assessment (including forensic examination) for abuse/trafficking victims
  - the needs and circumstances of victims of domestic violence, rape, trafficking, etc.
  - permission, privacy, confidentiality, etc. issues
  - case management, as practiced by the facility, including the use of the Psychological Assessment Form



- A Psychological Assessment Form is present (may be part of a larger Assessment Form)

### **7.5 Legal assessment**

Situation, Requirements and Actions regarding legal assessment are not included in this document.

### **7.6 Social assessment**

**Rationale:** To plan treatment and rehabilitation, a social assessment of the victim is conducted. Information is collected regarding her social needs, problems, advantages and general situation, as well as on her family situation, trafficking history, etc. The social assessment is taken from the victim, not her family (see Family and Community Assessment). **Note:** To avoid retraumatization, the social assessment (or those parts of the assessment relating to abuse, rape, trafficking history, etc.) is conducted only by a fully trained counselor, social worker, psychologist or psychiatrist. A person not fully trained in counseling skills should not ask questions of a victim regarding her abuse, rape, trafficking history, etc.

#### Actions

- The victim is provided a social assessment within 21 days after arriving in the facility.
- The Social Assessment Form is completed and placed in the victim's case file.
- The social problems/needs (if any) of the victim are recorded in the Assessment Summary.
- If the assessment takes place outside the facility, a designated staff person is continually present to support the victim.

#### Requirements

- Guidelines for social assessment are present
- A staff person who has received adequate clinical-based counseling training, a psychologist or a psychiatrist is designated to conduct social assessment.
- These person are appropriately trained. Training includes:
  - social assessment for abuse/trafficking victims, as per guidelines
  - the needs and circumstances of victims of domestic violence, rape, trafficking, etc.
  - permission, privacy, confidentiality, etc. issues
  - case management, as practiced by the facility, including the use of the Social Assessment Form
- A Social Assessment Form is present (may be part of a larger Assessment Form)

### **7.7 Literacy/skills assessment**

**Rationale:** A literacy/skills assessment is conducted in order to plan the provision of education, life skills and occupational training to the victim. **Note:** 'Education' is not the equivalent of 'literacy' : some persons have become literate outside the education system, and other persons are illiterate despite having been in the education system. It should also be noted that 'literacy' is a gradient, not an 'either/or' situation. The extent or level of literacy should be determined. Literacy can only be determined by examination. Skills assessment includes both household skills (cooking for the home, sewing) and occupational skills (cooking for restaurants, tailoring).



### Actions

- The victim is provided a literacy/skills assessment within 21 days after arriving in the facility.
- The Literacy/skills Assessment Form is completed and placed in the victim's case file.
- The literacy/skills problems/needs (if any) of the victim are recorded in the Assessment Summary.

### Requirements

- Guidelines for literacy/skills assessment are present
- Tools for literacy/skills assessment are present (oral/written literacy tests, skills tests)
- Designated staff are trained in the activities described in those guidelines, and in the use of the tools.
- A Literacy/skills Assessment Form is present (may be part of a larger Assessment Form).

## **7.8 Participatory future plan assessment**

Rationale: All persons in care, child or adult, have right to participate in all matters that affect them, including decisions about their occupational training, education and reintegration. Caregiving facilities provide a means by which victims can identify goals, make decisions and decide their futures. These conclusions are recorded in the Participatory Future Plan Assessment and used in treatment and rehabilitation planning.

Note: This 'assessment' is usually not conducted at one time, but is a record of the conclusions of the victim arrived at during future planning and goal-identification activities, which are usually part of the life skills curriculum.

### Actions

- The victim is provided with a participatory future plan assessment within 30 days after arriving in the facility.
- This assessment is conducted regularly and updated throughout the victim's stay in the facility, according the completion of life planning, career planning and goal-identification activities.
- The Participatory Future Plan Assessment Form is completed and placed in the victim's case file.
- The problems/needs (if any) of the victim are recorded in the Assessment Summary, and updated throughout the victim's stay in the facility.

### Requirements

- Guidelines for participatory future plan assessment are present.
- Tools for participatory future planning are present (life planning, career planning, goal-identification activities, etc. – usually part of a life skills curriculum).
- Designated staff are trained in the activities described in those guidelines, and in the use of the tools (this may include life skills teacher training).
- A Participatory Future Plan Assessment Form is present.

## **7.9 Family and community assessment**

Rationale: A family and community assessment is conducted in order to clarify the victim's home living situation, the needs of her and her family (including husband and husband's family if she is married or intends to get married), and possible risks from either family or community members. Note: This is a field assessment of the family and



community done at the location of the family and community. Some information may be gathered from the family if they visit the facility – but this information is insufficient and not necessarily reliable. This assessment is conducted by persons trained in social work methodologies, including professional and/or para-professional social workers.

#### Actions

- An assessment of the victim's family and community is conducted within 30 days after the victim's arrival in the facility.
- The Family and Community Assessment Form is completed and placed in the victim's case file.
- The problems/needs (if any) of the victim, family and community are recorded in the Assessment Summary.

#### Requirements

- Guidelines for family and community assessment are present
- Tools for family and community assessment are present
- Designated staff are trained in family and community assessment
  - basic social work skills (professional or para-social work training)
  - the activities described in those guidelines, and in the use of the tools
  - the needs and circumstances of victims of domestic violence, rape, trafficking, etc.
  - permission, privacy, confidentiality, etc. issues
- A Family and Community Assessment Form is present.

## **8. CASE PLANNING AND REFERRAL**

### **8.1 Case meetings**

Rationale: Case meetings ensure that all persons in care is provided with regular consideration regarding their treatment and reintegration by all persons responsible for their care. In the early case meetings for each victim, a Protection Plan (if necessary), a Treatment Plan and a Reintegration Plan are created. In subsequent case meetings, the progress of the victim according to these plans is reviewed, and modifications/additions to the plans are made. Prior to discharge or referral, a final evaluation meeting is conducted. While 'emergency' case meetings for victims with special problems are conducted as necessary, case meetings are routinely conducted for every person in care, from intake to discharge or referral.

#### Actions

- The case of every victim is reviewed in a case meeting within 15 days after intake and each 60 days or less thereafter for as long as the person is in the facility.
- The case meeting is chaired by the designated case manager, and is attended by facility staff responsible for the victim's care (Warden, counselor, etc.) and, as necessary, out-facility professionals who are responsible for their care.
- Case meetings are conducted according to the case meeting guidelines.
- Output of case meetings is recorded and placed in the victim's case file.

#### Requirements

- Guidelines for case meetings are present.
- All staff responsible for any aspect of victim's care as well as all out-facility professionals involved in their care (doctors, lawyers, psychologists, police, etc.) are trained in those guidelines.



## **8.2 Protection Planning**

**Rationale:** Some victims require ongoing protection measures. These are identified during the Protection Assessment. To ensure the protection of the victim and her children (if necessary), a protection plan is created, protection activities are conducted according to the plan, and the protection status of the victim is periodically reviewed in case meetings. For some victims, the Protection Assessment may indicate that there is no need for protection planning.

### **Actions**

- A Protection Plan, if needed for the protection of the victim or her children, is developed within 15 days after intake, and reviewed every 30 days until the time that the victim or children no longer need special protection.
- Case meetings in which the Protection Plan is developed and reviewed are chaired by the designated case manager and attended by all staff responsible for the victim's protection as well as, as necessary, all out-facility professionals involved in her protection (lawyers, police, etc.)
- Output of the meetings are recorded and placed in the victim's case file.

### **Requirements**

- Guidelines for protection planning and review are present.
- All staff responsible for the victim's protection as well as all out-facility professionals involved in her protection (lawyers, police, etc.) are trained in those guidelines.
- A Protection Plan Form is present, and contains:
  - areas of protection (abuser, family, self, trafficker, other)
  - goals, actions, responsibilities and time frame

## **8.3 Treatment (Rehabilitation) Planning**

**Rationale:** A Treatment Plan is developed for every victim who enters care. The Treatment Plan is developed according to the Assessment Summary (Problem List). All relevant persons (both staff and out-facility) responsible for the victim's rehabilitation are involved in the development and periodic review of the Treatment Plan. **Note:** The victim is a participant in treatment planning, and her input/permission is solicited for all goals and actions. In the case of a minor, the family participates in treatment planning, if possible and if relevant.

### **Actions**

- A Treatment Plan is developed within 30 days after intake, and reviewed every 60 days or less thereafter for as long as the victim is in the facility.
- Case meetings in which the Treatment Plan is developed and reviewed are chaired by the designated case manager and attended by all staff responsible for the victim's treatment as well as, as necessary, all out-facility professionals involved in her treatment.
- Output of the meetings are recorded and placed in the victim's case file.

### **Requirements**

- Guidelines for treatment planning, including the participation of the victim, are present.
- All staff responsible for the victim's treatment as well as all out-facility professionals involved in her treatment are trained in those guidelines.
- A Treatment Plan Form is present, and includes:



- Short-term plan
- Long-term plan (if necessary)
- Plan Content, which includes:
  - goals, matched to Assessment Summary (Problem List)
  - actions
  - responsibility
  - timeframe
- Plan Focus, which includes:
  - health
  - emotional and behavioral development
  - legal
  - education and skills
  - legal identity (ID card, citizenship, marriage certificate, birth registration, etc.)
  - family unification and social relationships
  - securing employment or income

#### **8.4 Reintegration Planning**

**Rationale:** Central to quality care is the assurance of rapid, effective reintegration for every person who enters care. Reintegration planning and activities begin when the victim enters care. A Reintegration Plan is developed for every victim who enters care. Reintegration goals are developed according to the Assessment Summary (Problem List). All relevant persons (both staff and out-facility) responsible for the victim's preparation for reintegration (Case Manager, Occupational Skills teacher, literacy teacher, Life Skills teacher, Social Worker, etc.) are involved in the development and periodic review of the Reintegration Plan. **Note:** The victim is a participant in reintegration planning, and her input/permission is solicited for all goals and actions. For both adults and minors, the family participates in reintegration planning if possible and if relevant.

#### **Actions**

- A Reintegration Plan is developed within 60 days after intake, and reviewed every 60 days or less thereafter for as long as the victim is in the facility.
- Case meetings in which the Reintegration Plan is developed and reviewed are chaired by the designated case manager and attended by all staff responsible for the victim's reintegration as well as, as necessary, all out-facility professionals involved in her reintegration.
- Output of the meetings are recorded and placed in the victim's case file.

#### **Requirements**

- Guidelines for reintegration planning, including the participation of the victim, are present.
- All staff responsible for the victim's reintegration as well as all out-facility professionals involved in her reintegration are trained in those guidelines.
- A Reintegration Plan Form is present, and includes:
  - Both a short-term plan and a longer-term plan (if necessary)
  - Plan Content, which includes:
    - goals, matched to Assessment Summary (Problem List)
    - actions
    - responsibility



- timeframe
- Plan Focus, which includes:
  - pre-reintegration activities – occupational
  - pre-reintegration activities – life skills
  - activities to prepare for reintegration – family contact, pre-reintegration assessment of family/community, trial living situation, referral, etc.
- Planning decisions are based upon:
  - Social, Literacy/skills, Participatory Future Plan, and Family and Community Assessments
  - discussion with victim
  - outcomes of life-planning activities conducted with the victim

### **8.5 Referral to other facilities**

**Rationale:** The victim may be referred to other facilities for a number of reasons. The victim:

- needs constant professional medical care (referral to hospital or care home);
- is dying (referral to hospice);
- has disabilities which cannot be attended in the facility (referral to care home for the disabled);
- has psychological problems which cannot be attended in the facility (referral to psychiatric care facility);
- has severe discipline or criminal problems (referral to juvenile home or prison);
- is a minor with no family/community living options (referral to orphanage, foster home or group home)
- desires or needs an intermediate living situation prior to reintegration (referral to group home or half-way home)

In any situation of referral, the facility has an obligation to ensure that the referral is appropriate and beneficial to the victim, and that the alternative facility provides quality care. **Note:** The victim has the right of participation (with protection considerations) in decisions affecting her referral.

#### **Actions**

- A referral decision is made, in consultation with the victim, in a case meeting which include the Case Manager and all staff and out-facility professionals responsible for the areas of treatment and reintegration concerned with the reasons for the referral decision (ex. doctor for referral to medical facility, psychiatrist/psychologist for referral to psychiatric facility, etc.)
- If referrals have not been made to the destination facility within the previous 12 months, a pre-check of the facility is undertaken.
- Prior to referral, meetings are conducted between facility staff and relevant professionals and the staff/professionals of the destination facility in which the victim's case is discussed.
- The victim is provided with orientation on the destination facility.
- Following the referral, facility staff conduct follow-up meetings with the victim and the destination facility staff within 30 days after referral and each 90 days thereafter for 180 days.
- The referral process is documented and placed in the victim's case file.



- The Referral Form is completed, and provided to the destination facility along with necessary documents from the victim's case file.

#### Requirements

- Guidelines for the referral process, including the participation of the victim, are present, and include:
  - participation of the victim in decisions
  - clear reasons for the referral decision
  - pre-check of referral facility for level of care
  - follow-up with victim after she is referred to facility
  - appropriate documentation of the referral process
- All staff responsible for the victim's treatment and reintegration as well as all out-facility professionals involved in her treatment and reintegration are trained in those guidelines.
- A Referral Form is present.

### **9. SOCIAL ENVIRONMENT**

Rehabilitation and reintegration are most effective in an environment that is comfortable, friendly and encourages positive relationships among residents and staff. Environments that are institutional and impersonal discourage healing and can even have a negative impact on the well-being of residents. Residents clearly understand the daily operations, rules and regulations, and disciplinary rules of the facility, while being provided basic rights of self-identity, confidentiality, privacy and access to the family and the world outside the facility.

#### **9.1 Daily Activities**

Rationale: Daily Activities are conducted according to a routine that provides structure and predictability to the residents, and residents participate in the routine maintenance activities of the facility.

#### Actions

- A daily activities schedule is created in participation with the residents.
- The activities schedule is posted, and residents who are illiterate are informed of the daily schedule.
- Residents conduct routine maintenance activities (cleaning, cooking, etc.).

#### Requirements

- A daily activities schedule is present and available to the residents.

#### **9.2 Rules and regulations for residents**

Rationale: A care facility operates under clear rules and regulations for residents that include, among others: general conduct, required activities; relationships between residents and staff; permitted and forbidden activities; visitors; conduct of residents and accompanied children; etc. Some rules and regulations are 'non-negotiable' and are developed and enforced by the facility; other rules and regulations are created and enforced through the participation of the residents.

#### Actions

- The residents are aware of and abide by the rules and regulations of the facility.
- All residents sign a formal or informal 'contract' stating that they understand and agree to abide by the rules and regulations.



### Requirements

- Rules and regulations of the facility are present and available to the residents.
- Guidelines for the enforcement of rules and regulations are present.
- Staff are trained in the content and enforcement of rules and regulations.

### **9.3 Discipline**

Rationale: Discipline problems arise in almost every caregiving environment with adolescents and young adults, particularly those who have come from disturbed family environments, from the street, or from commercial sexual exploitation. Clear, firm disciplinary procedures – without resort to corporal or psychological punishment – are necessary to protect residents and staff, to maintain harmony in the facility, and to provide a learning experience for the residents.

- Actions
- Discipline is maintained in the facility through positive methods.
- Residents participate in enforcing discipline.

### Requirements

- A policy on discipline is present.
- Disciplinary procedures, including participatory methods of enforcing discipline, are present.
- Facility staff are trained on discipline, including:
  - the psychological and social background of disciplinary problems
  - the facility's policies and procedures on discipline
  - positive discipline theory and techniques
  - prohibited disciplinary activities (corporal punishment, humiliation, deprivation, confinement, demeaning or degrading actions, etc.)
  - Therapeutic Crisis Intervention (safety and containment of violent or uncontrolled persons)
- Residents are aware of disciplinary policies and procedures.

### **9.4 Reporting of complaints and problems**

Rationale: A complaint and problems reporting system ensures the well-being of residents and prevents the occurrence of conflicts between residents and staff or other residents. Residents report complaints and problems to a person who is not involved in the direct supervision or control of the residents, such as a counselor or social worker.

### Actions

- Residents have an opportunity to report complaints and problems without fear of reprisal.

### Requirements

- A complaint and problems reporting system is present.
- Staff members not involved in direct supervision of residents are identified to respond to the personal concerns of the residents.

## **10. HEALTH CARE AND NUTRITION**

Not covered in this document.

## **11. CARE FOR ACCOMPANIED CHILDREN**

Not covered in this document.



## 12. LEGAL SUPPORT, JUDICIAL PROCEEDINGS

Not covered in this document.

## 13. PSYCHOSOCIAL CARE

### 13.1 Policies on psychosocial care

Rationale: Residents who have been sexually abused, trafficked or are HIV-positive persons may be re-traumatized or harmed by 'counseling' conducted by untrained persons or by inappropriate psychosocial practices. Policies ensure the professionalism and conduct of psychosocial care according to universal standards and guidelines.

#### Actions

- Psychosocial care is conducted by appropriately trained persons according to standardized methods.

#### Requirements

- Policies on psychosocial care are present, and include, among others:
  - Use of psychosocial interventions is decided only by a professional psychologist or counselor of the case management team, and psychological interventions are conducted only according to the resident's case management plan.
  - With the exception of emergency and crisis situations, the resident participates in all decisions regarding psychosocial interventions on her behalf.
  - Counseling for sensitive problems, crisis situations, severe emotional states, or severe psychological disorders is conducted only by appropriately trained and experienced persons, in accordance with the training standards and competencies guidelines of the organization.
  - Counseling is conducted in a safe, comfortable and private environment.
  - All principles of confidentiality are applied to counseling activities.
  - Appropriate referral procedures are conducted (see 'Referral to other facilities').
- All staff working directly with residents are oriented on the policies for psychosocial care, and on the roles of para-counselors and professional counselors.

### 13.2 Counseling activities conducted by professionals (counselors, psychologists or psychiatrists)

Rationale: Counseling activities for certain psychological conditions can only be conducted by appropriately trained professionals.

#### Actions

- Residents are provided counseling by professional counselors, psychologists or psychiatrists for sensitive problems, crisis situations, severe emotional states or severe psychological disorders.

#### Requirements

- Professional counselors, psychologists or psychiatrists are hired or are available.
- These persons have been trained in, among others:
  - general person-centered counseling
  - rape and abuse counseling



- crisis counseling
- trauma counseling (PTSD, Critical Incident Stress Debriefing)
- group counseling for critical concerns

### **13.3 Counseling activities conducted by para-counselors (as well as professional counselors, psychologists or psychiatrists)**

**Rationale:** Many psychosocial interventions, particularly those that enhance mental health and social skills, can be effectively conducted by persons who are trained as para-counselors. **Note:** In this document, 'training' signifies only instruction which includes observed clinical practice. Instruction without clinical practice is designated 'orientation' in this document, and does not qualify a person to conduct psychosocial interventions.

#### **Actions**

- Residents are provided counseling by trained staff and professionals for non-critical emotional concerns and for situational concerns such as pregnancy and drug abuse.
- Residents are provided activities to promote mental health and well-being.
- Staff are provided counseling and care-for-caregivers support.

#### **Requirements**

- Selected staff are trained and designated as para-counselors, or para-counselors are hired.
- Professional counselors, psychologists or psychiatrists are hired or are available.
- These persons have been trained in, among others:
  - preliminary assessment ('warning signals') of severe psychological problems
  - general psychological well-being (communication skills, emotional management, relaxation, anxiety-reduction, confidence-building, trust-building, etc.)
  - experiential psychosocial activities (play therapy, art therapy, dance therapy, etc.)
  - group counseling for general concerns
  - pregnancy counseling
  - drug counseling
  - conflict mediation
  - staff counseling (conflict mediation, de-stressing, critical incidence stress debriefing)

### **13.4 VCT for HIV/AIDS and STIs**

**Rationale:** Voluntary Counseling and Testing (VCT) for HIV/AIDS and STIs may be required upon request of the resident, particularly if identified and recommended by the medical examiner. For reasons of confidentiality and professional service, VCT services are generally obtained outside the facility.

#### **Actions**

- Residents are provided with VCT services for HIV/AIDS and STIs by a trained person in a confidential setting.

#### **Requirements**

- VCT services with trained VCT counselors are identified.



### **13.5 Peer counseling activities**

**Rationale:** Residents can, with training and guidance, provide non-critical counseling and support to their peers.

**Actions**

- Residents provide peer counseling and support to peers.

**Requirements**

- Para-counselors and/or professionals are trained in training and guiding peer counselors.
- Selected residents are trained in peer counselor and 'buddy' support activities.

## **14. EDUCATION AND RECREATION**

### **14.1 Education**

**Rationale:** Access to education is a right of all persons in care, whether children or adults, and an obligation of the care facility, however long the person is within the facility. For minors in care, education is compulsory, with all consideration for the needs and protection of the child. For children with little or no formal education, emphasis is placed on mainstreaming the child into the formal education system. However, when placing the child within a formal school system, care is taken to protect the child from possible discrimination due to his/her past experiences, present situation or medical condition. Supplementary education (including, among others, health, hygiene, nutrition, reproductive health and parenting skills) is provided if not part of the existing educational curriculum.

**Actions**

- Victims are consulted regarding their wishes and needs regarding education.
- Formal education in local schools (with all considerations for protection) is provided for children with basic literacy.
- Non-formal education for children without literacy is provided to the level necessary for enrolling in formal education.
- Appropriate education, either formal or non-formal, is provided to adult victims, in accordance with their wishes.
- All residents of the facility are provided with supplementary education.
- In addition to time provided to pursue education, the facility provides victims privacy and time to pursue studies, as well as assistance by staff.
- School records of all victims are formally kept, and provided to the victim upon discharge.

**Requirements**

- Guidelines for provision of education according to the literacy/skills assessment are present, including activities to ensure the participation of victims in decisions regarding their education.
- Facility staff and out-facility persons who provide non-formal education are appropriately trained and experienced.
- Appropriate access is available to supplementary education, which includes, among others, health, hygiene, nutrition, reproductive health and parenting skills.
- Facility staff and out-facility persons who provide supplementary education are appropriately trained and experienced.
- The facility has adequate quiet space for victims to study, and sufficient books, news materials and educational materials for victims' needs.



## 14.2 Recreation

**Rationale:** Caregiving facilities frequently underestimate the importance of planned and supported recreational activities. Appropriate recreational activities are essential to healing and strengthening victims, and are frequently more effective than either counseling or education. Recreational activities can provide opportunities for learning communication skills, socially appropriate behaviors, participation, problem-solving, trust-building and confidence-building, as well as providing release of tensions, relief from anxiety and depression, and opportunities to share concerns with peers in a relaxed, open atmosphere. Recreational activities can also provide exposure to outside society, and assist in building the victim's confidence and social skills necessary for reintegration. Recreational activities go beyond passive relaxation activities, such as watching television or playing games, to include physical activities, creative/artistic activities such as drawing, music and dance, and cultural activities.

### Actions

- All residents are provided routine, scheduled recreational activities, both indoors, outdoors and outside the facility.

### Requirements

- Guidelines for recreational activities inside and outside the facility are present and include:
  - provision of a schedule of organized recreational activities
  - provision of a wide and appropriate range of recreational activities that develop the physical, social and interpersonal strengths of the victims, including athletic activities, creative/artistic activities and cultural activities
  - provision of activities outside the facility, which allow victims interaction with the wider community environment
  - 'one-on-one' support of victims by staff to encourage individual creative expression and physical development
  - 'one-on-one' support of victims by staff to personalize their experience through, for example, the celebration of birthdays, name days and cultural and religious occasions
  - recreational activities include expressions of the local culture, including songs, dances, stories, visits to sites, etc.
- Designated facility staff are trained in recreational activities.
- Recreational equipment and recreational materials are present.
- A recreation plan is present, including daily scheduled recreational activities and routine outside excursions.
- The facility has adequate space indoors and outdoors for recreational activities.

## 15. OCCUPATIONAL TRAINING AND PLACEMENT

**Rationale:** Occupational training is accompanied by additional activities, as follows. Each person is given an opportunity to choose, within however limited options, the income-generating activities they wish to pursue. The facility ensures that the training provided prepares the victim for work that is readily available, safe and sufficiently remunerative. In order that victims can save their earnings and establish themselves economically, occupational training is accompanied by training in basic household savings and domestic financial management, business management if appropriate, and networking



with community banking and other monetary institutions. Finally, victims are assisted in placement in work situations before or after discharge from the facility.

- Actions
- The victim is provided with occupational training, based on her Literacy/skills assessment, on her life planning and career planning activities (provided as part of life skills activities), and on the realistic appraisal of work availability.
- The victim is provided with training in basic household savings and domestic financial management, business management if appropriate, and networking with community banking and other monetary institutions.
- The victim is provided with placement in employment or supported to establish a micro-enterprise before or after discharge.

#### Requirements

- Guidelines for occupational training and placement are present.
- Life planning and career planning activities (part of the life skills curriculum) and other activities are present to ensure the participation of victims in decisions regarding their future income generation.
- Training activities are present which assist the victim to save earnings, operate businesses, take loans, etc. (part of the life skills curriculum)
- The facility conducts activities, such as informal surveys, to identify work for victims that is readily available, safe and sufficiently remunerative.
- Staff conducting occupational training are appropriately trained.
- If the facility conducts occupational training, appropriate training space, equipment and materials are present.
- If the facility does not conduct occupational training, collaboration with training institutions and organizations is established.
- Networks and contacts are established with community banking or other monetary institutions.
- Networking, collaboration and other mechanisms are present to ensure that victims are placed in employment or can establish micro-enterprises either before or after discharge.

## **16. SOCIAL REINTEGRATION (LIFE SKILLS) TRAINING**

Rationale: For many victims, occupational training alone is insufficient for successful reintegration. Victims frequently face stigma and discrimination from family and community; lack self-confidence, social skills and communication skills; undergo harassment from men and persons in authority; and lack the skills to deal with alienation, loneliness, abuse, negative emotions, etc. As well as psychological and physical healing and employment training, rehabilitation and reintegration activities includes strengthening the victim to live as an assertive, responsible person in a challenging society. This is provided through life skills training.

#### Actions

- All residents are provided with comprehensive life skills training, however long they remain in the facility.

#### Requirements

- Guidelines for social reintegration (life skills) training are present.
- A comprehensive life skills curriculum is present and includes skills in, among others:



- goal identification, life planning, career planning
- household savings and domestic financial management
- interpersonal communication
- building self-esteem, self-confidence, trust
- assertiveness and conflict resolution
- decision-making and problem-solving
- social and physical presentation
- emotional management
- dealing with stigma and discrimination
- preventing substance abuse
- gender and rights awareness
- negotiating/living with peers, family, husbands
- marriage and parenting
- self-protection from abuse, violence, harassment, etc.
- sexual and reproductive health
- general health, nutrition and hygiene
- Designated staff are trained in conducting life skills training.
- Appropriate learning space and materials for life skills training are present.

## 17. PRE-REINTEGRATION ACTIVITIES

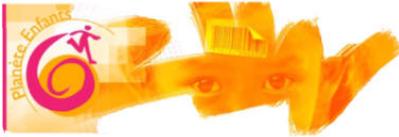
Many victims suffer abuse and harassment after reintegration, sometimes necessitating a return to care. Victims are not returned to families, communities or spouses who have previously abused or trafficked them without being provided adequate protection. It is a core obligation of a care facility to ascertain, prior to reintegration, if abuse, re-trafficking, etc. will occur; if such is likely to occur, it is the responsibility of the care facility to find an alternative living situation for the victim. Before discharge from the facility, the victim and her family, community or husband are prepared for the reintegration. This is generally the task of the trained social worker or para-social worker. The pre-reintegration family/community assessment includes an economic assessment of the destination living situation, to ascertain if economic support is required after reintegration, and a mapping of persons and organizations who can provide social, economic and protective support to the victim following her return.

### 17.1 Pre-reintegration family/community assessment

**Rationale:** It is necessary to ascertain whether the family, community or spouse will abuse, re-traffic or otherwise harm the victim upon her return, and if the victim and destination family/spouse will need economic assistance. This assessment is conducted in the field, in the family and community environment.

#### Actions

- Prior to reintegration, assessment of the victim's destination family, community and/or husband is conducted.
- This assessment is recorded, placed in the victim's case file, and taken into consideration during the Final Case Review meeting in which the victim's Reintegration Plan is reviewed.
- If the assessment indicates the probability of harm to the victim, either protection mechanisms are established in the family and community, or an alternative destination is determined for the victim.



- If the assessment indicates a need for economic support following reintegration, post-reintegration actions are planned.

#### Requirements

- Guidelines for pre-reintegration assessment are present.
- Tools for pre-reintegration assessment are present.
- Facility staff include either a professional social worker or persons adequately trained as para-social workers.

### **17.2 Planning of post-reintegration activities**

Rationale: To ensure successful reintegration, follow-up support activities are conducted for the victim as needed, usually for approximately 6 months after discharge. Following reintegration, the victim and her family/spouse may require protection from abuse, economic support or training, counseling for family or marital problems, assistance in getting education or intervention in the case of trauma, abuse or other crises.

Consequently, activities which follow the victim's discharge from the facility are planned.

#### Actions:

- Activities to support the victim after discharge and reintegration, if any, are planned, and attached to the victim's Reintegration Plan.

#### Requirements

- Guidelines for post-reintegration planning, including the participation of the victim, are present.

### **17.3 Preparation of victim, family, community, spouse**

Rationale: Both the resident and the destination family, community and/or spouse is prepared for the victim's return. Preparation includes counseling activities to obviate conflicts upon return, activities to reduce stigma and discrimination against the victim, activities to ensure successful income-generation by the victim and her family/spouse, and networking to provide local support for the victim. In some cases – such as situations of previous abuse by family members or the likelihood of discrimination against the victim – preparatory meetings of the victim and family members or short-term trial living situations may be necessary, in order to allow the victim and family members to adjust to the victim's return.

#### Actions

- Prior to reintegration the victim is provided with counseling, final economic preparation and links to persons and organizations in her destination.
- The family, community and spouse are provided with counseling, information necessary to support the victim's return, and other support as needed.
- Individuals and organizations in the community (teachers, police, women's groups) are contacted and enlisted to provide support for the returning victim.
- If deemed necessary, preparatory meetings between the victim and family members and/or short-term trial living situations are conducted before the victim leaves the facility.

#### Requirements

- Guidelines for preparation of victim, family, community and spouse are present, and include:
  - psychosocial/counseling preparation to obviate conflict, stigma and discrimination
  - economic preparation



- networking to provide a support system for the victim
- Facility staff include either a professional social worker or persons adequately trained as para-social workers, and these staff are trained in preparation of victim, family, community and spouse.

#### **17.4 Discharge**

**Rationale:** At the end of the processes of treatment and preparation for reintegration, the victim is discharged.

##### Actions

- Final Evaluation of the victim is conducted and includes evaluation of the status of the victim vis-à-vis intake and ongoing assessments regarding:
  - physical health needs
  - psychological needs
  - social needs
  - legal service needs
  - education/skills needs
- A Final Case Review Meeting is conducted, with participation by all members of the victim's case management team, including the victim, and includes:
  - review of the progress of the Treatment and Protection Plans towards goals
  - review of the Reintegration Plan, including planned post-reintegration activities
  - assessment of victim's preparation for return to community
  - input and feedback from the victim regarding her stay in the facility
- Upon discharge, the victim's case management files are stored in a protected manner to ensure privacy and confidentiality of information.
- Requirements
- Final evaluation guidelines are present.
- A Discharge Form is present.
- Staff are trained in the discharge process.

#### **17.5 Activities prior to departure from the facility**

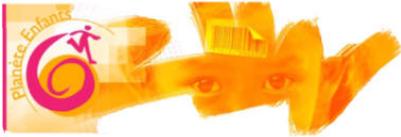
**Rationale:** The facility makes all efforts to ensure that the victim leaves the facility with dignity and self-confidence, oriented on her upcoming living situation, and with the physical effects necessary to begin a new life.

##### Actions

- The victim is provided with orientation regarding her destination.
- The victim is provided with contacts and referrals for support at her destination.
- If lacking, the victim is provided with new and appropriate clothing, shoes and other necessities.
- The victim is provided with school records, medical records, legal documents, savings and personal belongings.

##### Requirements

- Guidelines for activities prior to reintegration are present.
- Guidelines for pre-reintegration orientation are present.
- Staff are trained in conducting activities with victims prior to reintegration.



## **18. POST-REINTEGRATION ACTIVITIES**

**Rationale:** Post-reintegration activities are conducted up to 6 months after the victims leaves the facility and may include, among others:

- economic support or training
- assistance in getting education or training
- protection from abuse or trafficking
- counseling or mediation for problems with family, spouse or community
- intervention in the case of trauma, abuse or other crises.

**Note:** For concerns of privacy, confidentiality and protection, post-reintegration contact with the victim is only conducted with her consent and only under the conditions (for example, meeting the social worker or counselor away from her husband's home) which she identifies.

### **Actions**

- Consent is taken from the victim regarding post-reintegration contact and the conditions of that contact.
- Contact is made with the victim and, as needed, occupational support, counseling support, assistance in accessing education, and crisis intervention are provided.
- If a case of abuse is identified or trafficking is suspected, suitable response, including police intervention if necessary, for protection of the victim is made.
- Post-reintegration activities are documented and placed in the victim's case file.

### **Requirements**

- Guidelines for post-reintegration activities are present.
- Facility staff who are designated to conduct field visits include either a professional social worker or persons adequately trained as para-social workers, as well as professional counselors or persons trained as para-counselors.
- Designated staff and support persons (volunteers, supporting NGO members, teachers, etc.) are adequately trained in post-reintegration activities.

## **19. PHYSICAL FACILITIES**

**Rationale:** The health and psychological well-being of victims is dependent on the comfort and atmosphere as well as the space and amenities of the physical facility. It is important that the physical facility is home-like and that residents are allowed to 'personalize' their environment and their private space. As well, the manner in which the facility presents itself in the surrounding community affects the ways in which community accepts and interacts with the residents.

### **Actions**

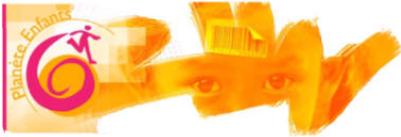
- Address the requirements below.

### **Requirements**

- The number of residents is appropriate to the size of the facility.
- The facility is appropriately maintained and lighted.
- The facility is painted and decorated in a comfortable, 'home-like' manner.
- The facility presents a modest image that facilitates residents' acceptance by the community, and does not publicly indicate the situation of the residents through signboards.



- Each resident has her own bed, a place to store her personal belongings and a places (walls, shelves) to personalize her private space with her own belongings (photographs, mementos, etc.).
- The facility provides the following:
  - sleeping rooms
  - personal/sleeping space for resident staff
  - staff work space and meeting space
  - counseling and family meeting space (private and quiet)
  - learning and activities space
  - recreation space
  - occupational skills training space (if skills training takes place)
  - medical treatment space (clinic room)
  - cooking area and eating area (separated)
  - bathing areas and toilet areas (separated)
  - emergency equipment (fire extinguishers, medical kit, etc.)
  - information place for residents: bulletin board
  - adequate security mechanisms
- The surrounding property provides the following:
  - walls or foliage for privacy
  - recreation area
  - laundry area
  - quarters and bathing/toilet area for security persons
  - adequate gates and security mechanisms



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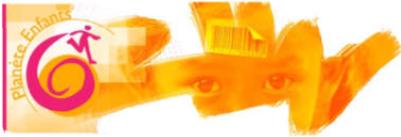


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## **ANNEX II. UNIVERSAL MINIMUM OPERATIONAL STANDARDS FOR RESIDENTIAL CARE FACILITIES**

Following is a 'model' of quality of care standards compiled from individual standards taken from different documents (see Annex I: References). This model is intended to serve a starting-point for discussion leading to the development of standards appropriate for countries as a whole, and for individual facilities. The points listed below are 'basic features' for standards which encompass the rights of the child survivor, functional operational guidelines, ethical principles of practice, responsible management, effective case management including reintegration, and care and consideration for staff.

### **A. CHILDREN'S RIGHTS**

- a) Children and their families are asked their opinions and participate in decisions about the children's lives and their future.
- b) On intake, children receive orientation on the purpose and operation of the facility, the roles of the staff, and the conditions of their residence. This is presented in child-friendly versions, in appropriate languages and explained to children who cannot read.
- c) The privacy and confidentiality of the child are ensured in all matters, and each facility has written policies on privacy and confidentiality. All staff are instructed in these policies, and they are made available to children. Areas of privacy and confidentiality include, among others:
  - 1) access to case records or other personal records
  - 2) sharing personal background, including names, with other than designated staff
  - 3) interviews, photographs or 'observation' of activities by press persons or others
  - 4) unrequested entry into children's 'private space' and access to their personal possessions
  - 5) personal matters, including hygiene and bathing facilities
  - 6) meetings and conversations with parents and family
- d) Children have the right of complaint according to written policy and guidelines. Their complaints shall be attended to without delay, and they may take complaints for representation to a person, such as a counselor, outside the facility.



- e) Children are allowed physical assets of personal identity and belongings. They may wear personal clothing on certain recreational occasions, secure their own requisites, have no interference in personal possessions, and are helped to look after their own money.
- f) Children have the right to maintain regular and personal contact with parents, family, friends and community (unless there are welfare considerations). Staff assist children in contacting and writing to their family.
- g) Children have the right to keep and use their given names, and to keep possession of or have access to personal legal documents.
- h) Residents, including legal children, have the right of access to and (unless there are welfare considerations) the right to care for their own children.
- i) Children are provided access to spiritual services, books, objects, teachers and religious holidays of their own religious conviction, and are free from obligation to engage in religious practices that are not their own.
- j) Support is available to enable disabled children to enjoy a range of activities, including recreation, education and occupational training.

## **B. CHILD PROTECTION**

- a) Facilities shall ensure a system to protect children from sexual abuse within the facility, including operational policies to prevent sexual abuse, and vetting of staff and visitors to prevent exposure to potential abusers.
- b) Facilities shall have guidelines and procedures to protect children from neglect, physical abuse from staff or other children, and self harm.
- c) Facilities shall provide immediate notification to authorities of significant events in the facility, including death, staff misconduct, illness, accident or communicable disease.
- d) Facilities shall have guidelines and procedures to follow in the case of a child's absence without authority, including notification of families and authorities, and appropriate action.
- e) Facilities shall have procedures, referral and notification systems for emergency situations. Facilities shall provide sufficient trained staff and accessible outside persons to attend to children's needs and emergency medical and psychological situations at any time of day or night. All core staff shall be trained in responding to emergency medical or psychological situations.

## **C. DISCIPLINE**

- a) Through positive responses, staff shall support the acceptable behavior of children, and in cases where behavior is unacceptable, staff shall provide



constructive, acceptable and known discipline according to clear written procedures.

- b) Written procedures for discipline shall be openly available to staff, children and parents.
- c) Staff shall receive training in disciplinary procedures, including the safety/containment of children with violent or other unacceptable behavior.
- d) Hitting, slapping, or any form of corporal discipline is prohibited.
- e) Children may not be punished or disciplined in a manner that demeans or degrades them, including verbal abuse or embarrassment in front of other children.
- f) Children may not be locked in small confined areas, or denied food, warmth, bathing, toilet or sleeping facilities.

#### **D. STAFF**

- a) Staff shall be selected according to, among other criteria, their capacity to relate to and interact with children.
- b) Staff shall be provided clearly defined job descriptions and understand their own and others' roles and responsibilities. Staff shall be provided clear, written guidelines on procedures and practice.
- c) The facility shall receive training in 'care-for-caregivers' and shall provide routine counseling and support for staff who are engaged in tasks directly related to children with psychosocial problems. Staff shall have access to a staff care scheme which they can access independently of line management, to discuss personal concerns and receive advice and counseling.
- d) Hiring and staff supervision practices shall include procedures to minimize possible abusers.
- e) Specific tasks (such as psychological assessment, trauma counseling, nursing, medical care, etc.) shall be undertaken only by persons with appropriate training and experience, as clarified in a general training standards/competencies document applicable to all facilities. The facility shall utilize outside persons for those tasks for which staff have insufficient training.
- f) All staff working directly with children shall receive training in child development, appropriate responses to sexualized behavior, de-escalation of anger, and group dynamics.
- g) All staff of each facility, including drivers, guards, etc., shall receive orientation on child abuse and exploitation, on confidentiality, and on supportive modes of interaction with the children.



- h) Staff are prohibited from any type of sexual, romantic or closely personal behavior with residents or former residents.
- i) The facility shall maintain a ratio of one staff person for every \_\_\_\_ children, and a ratio of caregivers (para-counselors, 'house mothers', recreational persons, etc.) of one caregiver to every \_\_\_\_\_ children.
- j) Good faith efforts shall be made to provide each child with a volunteer mentor who shall visit the child at least weekly. Mentors shall be permitted to take the child on trips away from the facility unless these is legitimate and documented concern about the child's absconding or safety for the child or the mentor.

## **E. PHYSICAL SURROUNDINGS**

- a) The capacity of a facility shall be based on function of the facility, the size of the facility and the number of staff.
- b) No facility shall have a capacity of more than \_\_\_\_ children.
- c) Each child shall be ensured a space of \_\_\_\_\_ square feet of the total indoor 'child-active' area of the facility (including sleeping rooms, recreation rooms, dining rooms, educational rooms, hallways, toilets, visitation rooms, medical rooms and counseling rooms). Offices, staff quarters, storage rooms, kitchen areas and other non-child-active areas will not be included in this calculation.
- d) Adequate space shall be provided for both group and individual play both indoors (at least \_\_\_\_\_ square feet per child) and outdoors (at least \_\_\_\_\_ square feet per child).
- e) The physical plant shall be kept clean, well-maintained, free of debris, well-ventilated and well-lighted.
- f) The facility shall have appropriate protection and mechanisms in case of fire and earthquake, and staff shall be trained on safety responses in case of natural disaster.
- g) All rooms shall be decorated in bright colors pleasing to children and provided with suitable and homelike decoration to make them comfortable.
- h) Security shall be provided by personnel, and bars and other prison-like forms of physical security shall not be permitted.
- i) Children shall be provided with a designated place to take meals, and shall not take meals in their sleeping area.
- j) Each child shall be provided with her/his own bed.
- k) Each child shall be provided with a sleeping/personal area of a minimum of \_\_\_\_\_ square feet.



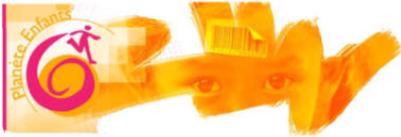
- l) Each child shall be provided with secure, private storage space for clothing and other personal items.
- m) Children shall be allowed to personalize their personal living area with photographs, decorations, etc. within reason.

## **F. HEALTH CARE AND NUTRITION**

- a) All children shall receive a medical and a dental examination within 5 days of admission.
- b) HIV/AIDS and STD testing shall be conducted only by request, and all results shall be kept within the confidentiality of selected members of the staff.
- c) All necessary medical and dental care shall be provided, including special care for the disabled.
- d) Each facility shall be open to access by and shall provide for the routine presence of a professional medical person from outside the facility.
- e) Immunizations shall be kept current.
- f) Health records shall be maintained and current. A copy of the health record shall accompany the child when she/he is discharged.
- g) Any specific therapeutic technique, diet, medication, etc. shall be used only upon a physician's recommendation, and only as part of the established Case Management Plan of the child.
- h) Children shall be provided varied and nutritious foods, including adequate amounts of protein and vitamin-rich foods.
- i) Children shall be provided with adequate physical exercise and adequate time for rest and sleep.

## **G. EDUCATION**

- a) All children shall be provided with formal education to the level of their ability and according to their wishes.
- b) Children who cannot read or write shall be provided with non-formal literacy education to the level necessary for enrolling in formal education. Attention shall be given to the parent language of each child.
- c) School records shall be formally kept, and proper documents shall be provided to the child when she/he leaves the facility.

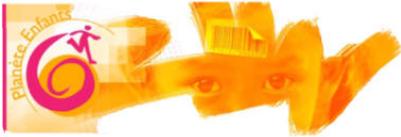


- d) Children shall be provided space, privacy and time to pursue studies, assistance by staff outside classroom time, and relevant and sufficient library materials, news materials, etc.
- e) In addition to the routine curriculum, all children are to be taught health, hygiene, reproductive health, age-appropriate expressions of sexuality, and appropriate ways of relating to men and to women.
- f) In addition, all children shall be provided with functional Life Skills Training, which will include basic living skills, managing money, caring for a home, and corresponding with family and friends, among others.

## **H. RECREATION AND CULTURE**

- a) Children shall be provided with adequate time for leisure, recreation and cultural pursuits.
- b) All children shall be taught the songs, dances, stories, and other expressions of their own culture.
- c) All children, including the disabled, shall have opportunities to participate in organized games and play activity, under the direction of the staff.
- d) All children shall have opportunities for child-directed individual or group play, without the intervention of staff except for safety purposes.
- e) Each facility shall have a recreational policy, developed in consultation with children, and shall have a full or part-time staff member dedicated to providing varied and interesting recreation for the children.
- f) The interests and abilities of individual children shall be assessed, and each child will be encouraged to engage in creative expression according to her/his own wishes.
- g) All children, including the disabled, shall have opportunity to participate in crafts, art, and other creative expression.
- h) Individual children shall be supported to celebrate personal occasions such as birthdays, name days, and cultural and religious festivals.
- i) All children shall have opportunities for excursions, picnics, etc. outside the facility in healthy recreational environments.
- j) Toys, games and other playthings appropriate to the age of the child in care shall be provided and available for use by the children. Safe and age-appropriate outside play equipment shall be provided.

## **I. CASE MANAGEMENT**



- a) Individual case management shall be conducted on standardized case management guidelines for each child, beginning at intake and ending upon completed reintegration.
- b) Written policies and standards shall be established regarding intake and evaluation procedures, treatment goals and plans, record-keeping requirements, client confidentiality and release of information, and maintenance of records.
- c) Individual case management, including regular case review and case planning, shall be conducted by a multidisciplinary case management team, which will be comprised of persons from both inside and outside the facility.
- d) The primary caregiving staff of each facility shall receive training on case management, and all caregiving staff shall receive orientation on the case management process.
- e) In the case management process, only professionally trained persons may authorize decisions/plans regarding medical care, psychological care and legal representation.
- f) The case management team, which will include a minimum of one professional psychologist, counselor or social worker from outside the facility, shall review the case of each child within 15 days after intake and each 60 days or less thereafter for as long as the child is in the facility. A Case Management Plan shall be developed with full participation of the child and, if possible, her/his family.
- g) The Case Management Plan shall include a Reintegration Plan (see below). This plan shall be developed with full participation of the child and, if possible, her/his family. The Reintegration Plan shall be developed within 60 days after admission and reviewed every 60 days thereafter.
- h) A Child Protection Plan, if needed for the welfare of the child, shall be developed within 15 days after admission, and reviewed every 30 days until the time that the child no longer needs special protection.
- i) Good faith and diligent efforts are to be made to locate parents within 30 days of admission and, unless there are overwhelming reasons to the contrary, to encourage parental involvement with the child. Any reasons for discouraging or not permitting parental involvement shall be discussed with both parents and the child, noted in writing in the child's records, and approved by the case management team.

## **J. PSYCHOSOCIAL INTERVENTIONS**

- a) Staff shall receive orientation on psychosocial care, and the specific roles and responsibilities of staff members and outside persons shall be clearly defined.
- b) Use of psychosocial interventions is to be decided only by a professional psychologist or fully-trained counselor of the case management team. With the



exception of emergency and crisis situations, the child shall participate in all decisions regarding psychosocial interventions on their behalf.

- c) Psychosocial interventions addressing trauma, PTSD, extreme emotional states, suicide, etc. shall be conducted only by professionally trained counselors, psychologists and psychiatrists, and in accordance with the case management process.
- d) Each facility shall make efforts to train staff and hire additional staff to provide psychosocial supportive activities, including para-counseling, play therapy, art therapy, confidence-building activities, and life-direction activities.
- e) Interaction, counseling, or 'helping' activities which involve discussion with a child of her/his history and experiences of abuse and exploitation shall be conducted only as prescribed in her/his Case Management Plan, and shall be conducted only by appropriately-trained and designated staff members.
- f) Psychosocial interventions shall be conducted in a private and confidential setting, and will take into account the child's language, culture, age, sex, ethnicity, class and religion.
- g) The facility shall make all efforts to provide caregivers who are of similar language, caste, class and ethnicity to the children.

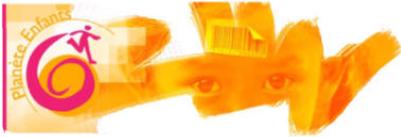
## **K. REINTEGRATION**

- a) Each child's Reintegration Plan (mentioned above as part of their Case Management Plan), shall be created with participation of the child, and will be based on an assessment of the child's skills and inclinations conducted by a trained counselor or guidance specialist,
- b) The child and, if possible, the child's family shall participate in all decisions regarding reintegration activities conducted on her/his behalf.
- c) The Reintegration Plan for each child shall include life planning activities, occupational development, and pre-reintegration orientation.
- d) In developing the Reintegration Plan, the case management team shall conduct assessment of the target community/family situation, and the Reintegration Plan shall be reviewed by the case management team prior to the child's discharge.
- e) Life planning activities shall be conducted to assist the child in determining goals, wishes and strategies for their future life. These shall be integrated into the child's Reintegration Plan.
- f) Occupational development shall include: career planning with the participation of the child and, if possible, her/his family; training the child in occupations clearly shown to provide adequate employment; assistance in finding on-site



apprenticeship training, if appropriate; and assistance in job placement or in establishing self-employment.

- g) Each facility shall provide training only in occupations which are suitable for proper, protected and viable employment of the child.
- h) Occupational training shall be accompanied by education in basic business management, household savings and fiscal management, and networking with community banking and other monetary institutions.
- i) Facilities shall not use children's labour for its own monetary purposes, and children shall not conduct labour by name of training unless it is appropriate to their future employment.
- j) Occupational training shall not interfere with children's basic education, recreation or free time.
- k) If the facility receives proceeds from the sale of products or labour from training activities, children shall have access to an equitable part of the proceeds for their individual use, will have control over those proceeds, and those proceeds will be protected by the facility.
- l) Prior to reintegration, the facility shall provide pre-reintegration orientation to each child, whether the child returns to her/his family, or enters a foster family or alternative living situation.
- m) Pre-reintegration orientation shall include awareness of social and economic opportunities and challenges to be faced, appropriate living skills, contacts with 'helping' persons and organizations outside the facility, and explanation of the facility's outreach/support mechanisms.
- n) Upon reintegration, the facility shall conduct outreach/support activities, or shall oversee the delegation of those activities to other organizations or individuals in accordance with the Reintegration Plan. Outreach/support activities shall be conducted only with permission of the child.
- o) Outreach/support activities shall include: counseling support visits to assist in psychosocial reintegration; occupational support visits to assist in economic reintegration and assist the child in developing self-employment, etc.; and crisis intervention in the case of abuse, trauma, etc.
- p) Upon discharge, each child shall be provided with school records, medical records, legal documents, savings and all personal belongings.
- q) Facilities shall make all efforts to ensure the dignity, self-confidence and well-being of the child at time of reintegration. If lacking, each child shall be provided new and appropriate clothing, shoes and luggage.



- r) Case management records retained by the facility shall be filed in a confidential and protected manner. The facility shall ensure the privacy, confidentiality and legal rights of all former residents regarding their past history, their residency in the facility, or their future situations.