Date

Abstract

This Information Sharing Agreement (ISA) provides authority for agencies with client consent to collect and disclose personal and health information to other participants on the basis of necessity, to the extent necessary for client support, to allow for determination of a coordinated, collaborative approach with the client.

Name of agencies providing wrap abour supports

Information Sharing Agreement

This project is funded through the generosity of Wage and Gender Equality Canada and the Alberta Council of Women’s Shelters. We also wish to express our gratitude to the participating organizations and individuals of the Grande Prairie community who continue to provide their time, expertise and commitment to this project.

Insert Logos and Names of Agencies who have signed the agreement so that future staff are aware that this document guides their agency’s collaborative efforts.

Table of Contents

[Setting the Direction 4](#_Toc90915794)

[Description of Project: 4](#_Toc90915795)

[Vision 4](#_Toc90915796)

[Purpose 5](#_Toc90915797)

[Key Audience/Stakeholders 7](#_Toc90915798)

[Outcomes 7](#_Toc90915799)

[Values/Principles 7](#_Toc90915800)

[Governance 8](#_Toc90915801)

[Organizational Structure 8](#_Toc90915802)

[Information Sharing Authority 9](#_Toc90915803)

[Dispute Prevention & Resolution 10](#_Toc90915804)

[Project and Procedure Review Schedule 10](#_Toc90915805)

[Information Sharing Agreement Terms 11](#_Toc90915806)

[Legislation & Information Management 12](#_Toc90915807)

[Overview of Privacy and Information Sharing in Alberta 12](#_Toc90915808)

[Information Management 12](#_Toc90915809)

[Confidentiality 13](#_Toc90915810)

[Information Flow: 14](#_Toc90915811)

[Program Controls 26](#_Toc90915812)

[A Consent-based Approach 26](#_Toc90915813)

[Gaining Informed Consent 26](#_Toc90915814)

[What to do if consent is refused 27](#_Toc90915815)

[Benefits of Sharing Information 28](#_Toc90915816)

[Benefits to Clients: 28](#_Toc90915817)

[Benefits to Agencies: 28](#_Toc90915818)

[Risk Management 29](#_Toc90915819)

[Risks of Sharing Information 29](#_Toc90915820)

[Risks of Not Sharing Information 29](#_Toc90915821)

[Outcome Goals and Indicators 30](#_Toc90915822)

[Blueprint of Promising Practices Impact Framework 30](#_Toc90915823)

[***A.*** ***Population:* Community partners/service providers** 30](#_Toc90915824)

[Impact 1 – Service providers grow their capability to inclusively and intersectionally engage all clients. 30](#_Toc90915825)

[Impact 2 – Service providers embrace client-centered collaboration. 31](#_Toc90915826)

[***B.*** ***Population:* Sector leaders** 32](#_Toc90915827)

[Impact 3 – Sector leaders develop adaptable, innovative learning organizations. 32](#_Toc90915828)

[Impact 4 – Sector leaders build a collaborative network of service providers. 33](#_Toc90915829)

[***C.*** ***Population:* Clients** 34](#_Toc90915830)

[Impact 5 – Clients engage systems of support. 34](#_Toc90915831)

[Impact 6 – Clients are safer. 35](#_Toc90915832)

[Common Terms / Definitions 36](#_Toc90915833)

[Signature Section 37](#_Toc90915834)

[Appendix A: SharePoint and App Data Fields 38](#_Toc90915835)

[Appendix B.1: Danger Assessment 42](#_Toc90915836)

[Appendix B.2: Danger Assessment – Walking the Path Together 43](#_Toc90915837)

[Appendix B.3: Danger Assessment – Immigrant Women 44](#_Toc90915838)

[Appendix B.4: Danger Assessment – Same Sex 45](#_Toc90915839)

[Appendix C: MOSAIC 46](#_Toc90915840)

[Appendix D: Goal Attainment 55](#_Toc90915841)

[Appendix E: CONSENT FORM 58](#_Toc90915842)

# *Note that all tools require training prior to their implementation.*

# Setting the Direction

## Description of Project: *Describe your project/initiative here (example follows)*

In Alberta there is no cross-sectoral standard approach or blueprint for the provision of services to those escaping domestic violence. A standardized approach to service delivery would include risk assessment, safety planning and solution-focused case management. It would also be informed by evidence-informed models including client centered care, trauma-informed services, and culturally appropriate services. A key component to achieving this goal is improving communication and collaboration amongst the service providers by:

* + - Enhancing the intersectionality, validity, and reliability of assessment tools that support the safety of clients and children fleeing domestic violence;
		- Developing and using common assessment tools and ongoing case management processes to improve client safety, support empowerment, and enhance community partners’ understanding of the critical importance of client-centered services, based on promising practices as identified by community organizations; and
		- Increase trust amongst community partner’s risk assessment processes and support their efforts enhance safety and ultimately to save clients’ lives.
		- Initial sharing will occur through an Iterative Learning Workshop and the development of an Information Sharing Agreement.

## Vision: *Describe your vision of working together here (example follows)*

The well-being and security of clients and their families will be improved by sharing information to identify and address health and safety, through collaboration and coordination across the partners in Name your region here.

The group will:

* + - Develop an Information Sharing Agreement (ISA);
		- Learn about and implement evidence-based risk assessment tools. Initially, starting with three assessment tools (e.g., Danger Assessment tool, The MOSAIC[[1]](#footnote-2) and Goal Attainment);
		- With client consent, collect and share information through the IRIS Care platform; and
		- Where identified, develop, improve, and evaluate other tools and processes (i.e., intake process, activity tracking, and discharge process).

Purpose: *Describe the purpose of your collaboration here (example follows)*

In Alberta there is no standard blueprint or process for risk assessment, safety planning and solution-focused case management. Cross sectoral collaboration requires mutual respect, durable organizational relationships and measurable standards for interventions. The standardization of the risk assessment process and wrap around solutions-focus on case management and safety planning, rather than an agency focused referral system. informed by survivors, our work will strive to improve communication and collaboration amongst the service providers.

1. **Risk assessment:[[2]](#footnote-3)** is used in protecting the safety of clients fleeing domestic violence. Comprehensive risk assessment is necessary to fully understand the level of risk that clients experience and their readiness for change, to account for their experience of trauma, and to develop an informed service plan.

Service providers and systems involved in addressing the issue of domestic violence use a variety of tools to assess and address the risk clients experience. Historically, there has been a focus on developing one standardized tool that would be accepted by all systems. However, in our experience, the real problem is that systems work in isolation using their preferred tools and potentially reaching different conclusions as to the service needs. This is particularly problematic for the most vulnerable clients, including those from sexual and gender minority groups, indigenous peoples, immigrants, newcomers, refugees, or those in rural and remote communities, when the assessment process and tools do not reflect their unique needs.

There is currently no comprehensive plan for a community process that allows all stakeholders to bring their tools, to validate multiple assessments and produce a comprehensive picture of clients’ needs. This process will introduce tools specifically focused on the needs of t clients, including the Danger Assessment, the MOSAIC and a Goal Attainment Scale.

1. **Cross-sector collaboration:[[3]](#footnote-4)** The interrelationship between violence, trauma exposure, inequality, social disadvantage, health problems, mental health difficulties, and homelessness requires a high level of coordination and collaboration amongst all services – government and community based– to ensure their clients’ safety and success in creating violence-free lives. Currently, multiple gaps are in place that create significant barriers to effective cross-sectoral collaboration:
	* + - Many systems are involved in domestic violence responses including: health, justice, education, immigration, settlement, child protection, social services, workplaces and community services. Navigation of multiple legal issues in criminal, family and child protection systems, significant barriers and inadequate supports for survivors and offenders, and inconsistency in system responses across the province contribute to the ineffectual prevention and response to domestic violence.
			- Although the provincial government recognizes the importance of cross-sector collaboration through the Family Violence Framework[[4]](#footnote-5), there is still insufficient resources and varying levels of commitment for these types of initiatives, exacerbating system and service access challenges.
			- Most communities do not have protocols for formal information sharing amongst service providers and systems. Open information sharing is essential in the provision of wrap around services and ensuring clients’ safety.

Cross sectoral collaboration requires mutual respect and measurable standards for interventions. A key component to achieving this is improving communication and collaboration amongst the service providers.

1. **Intersectional Policies and Service Provision:[[5]](#footnote-6)** Domestic violence impacts all socio-economic and cultural backgrounds. Circumstances surrounding the experience of domestic violence and service access for the most vulnerable clients make their access to services and positive outcomes much more challenging.
	* + - Systems have limited capacity[[6]](#footnote-7) to design and implement programs and services with a gendered lens and to effectively serve clients experiencing ongoing trauma from domestic violence. The gender, racial and cultural issues for those caught in domestic violence situations need to be addressed more fully. Those who are Indigenous, who identify as 2SLBGQT, or Non-Status, Refugee and Immigrants (NSRI) are more likely to experience prejudice and bias when trying to access services and report their domestic violence experiences.
			- There are also significant issues with service access in rural and remote communities – because of long distances, lack of transportation and lack of specialized services in the area. Oftentimes police are the only service available to respond and they too are challenged by the distances that need to be travelled in order to respond. Access to mental health and addiction services are particularly problematic specialized services.
2. **Wrap-around, Supportive Responses for Clients Experiencing Violence: Domestic Violence** is known to have long term consequences for the health and well-being of and to significantly impact their ability to fully participate in society. Abused individuals may require longer-term assistance to support their recovery and to lead productive lives. Promising practice models with individuals fleeing domestic violence focus on client-centered approaches, empowerment, trauma-informed care, integrated physical and mental health wellness services, safety, advocacy, accountability, and compassion. Recent studies have indicated that client vulnerabilities have an impact on risk and need to be identified and considered in wrap-around case management and safety planning. ([Please see Preventing Domestic Homicide in Canada: Current Knowledge on Risk Assessment, Risk Management and Safety Planning with Vulnerable Populations](http://cdhpi.ca/literature-review-report)).

## Key Audience/Stakeholders : *List your stakeholders here*

## Outcomes: *Describe your outcomes here (example follows)*

* Work with clients, stakeholder staff and community to develop, improve and evaluate implementation of the collaborative table including assessment tools, case management protocols, and reflecting the unique considerations for urban and rural communities, as well as clients who are Indigenous, NSRI and in 2SLGBTQ relationships.
* Support improvements to the tools and processes based on evidence produced through data collection and analysis.
* Work towards equality of outcomes by ensuring that all project participants have access to resources, participate in decision making and are recognised, valued and respected.
* Create affirming messages in work and training spaces to include those who the larger society has marginalized and/or from a minority background. Our advertising and promotion will be respectful and inclusive. Messages will consistently communicate open and welcoming attitudes, displaying relevant information, celebrating diversity, encouraging empowerment and inclusion at all levels of the project.
* We will work with our collaborative partners to develop supports based on the principle of equality of outcomes along the dimensions of race, ethnicity, gender, sexual orientation, socio-economic status, age, physical abilities, mental health status, religious beliefs, political beliefs, or other ideologies (e.g., access to CANTALK when language barriers arise).
* New staff/participants are trained on Blueprint and their roles and responsibilities as well as their organization.
* Support the enhancement of collaborative approaches underscored by a client-centered lens.
* Disseminate the findings broadly.

## Values/Principles: *Describe your values here (example follows). Review them frequently as new staff/new agencies become involved.*

Name of initiative believes that multiple agencies working together towards a common goal: to build safety, resiliency and respect for clients experiencing domestic violence will result in better outcomes for the community as a whole and decrease the harms to those clients.

# Governance

## Organizational Structure : *Example follows; role clarity is important; this needs to be something that works for your community.*

Through collaboration with community agencies in Alberta, the Blueprint Project Community Working Groups and Communities of Practice will contribute to the development of the assessment tools and case management protocols, and train front line staff in the implementation and use of the assessment tools case management protocols.

The Name of your collaboration will establish opportunities at provincial, local, and community levels to inform processes and tools, share results, as well as incorporate ad hoc member involvement.

1. **Blueprint Management Team (BMT)**: As the project manager, The Alberta Council of Women’s Shelters (ACWS) will provide project guidance, financial management and oversight. ACWS, through the Blueprint Management Team consists of ACWS staff and consultants, to support all project activities, including production and dissemination of materials, tools, processes training, evaluation, and on-going support, as well as the overall guidance for developing a community collaborative response. ACWS will guide the project through strength-based engagement with community partners by developing Community Working Groups, Communities of Practice, Community Subcommittees and a Provincial Working Group. The ACWS Director of Programs and Member Services carries primary responsibility for the project. The BMT will meet weekly.
2. **Community Working Groups** **(CWG)** with representation from local agency and shelter representatives the CWG will identify and discuss elements that contribute to meaningful community collaboration and promising practices for enhanced wrap around services; inform the development of an information sharing agreement and online sharing app; and provide feedback and enhancements to the assessment tools and case management protocol as appropriate for each community. The Committee will function as a wraparound service delivery partnership by ensuring documentation and protocols are in place to guide effective information sharing and individual case management planning and ultimately supporting the development of the final Blueprint. Select members of the working groups will represent their community on the Provincial Working Group. These committees will meet monthly.
3. **Provincial Working Group (PWG)** will provide a forum and act as a sounding board for participating communities to share thoughts, ideas and concerns about the implementation, training and development/refinement of the assessment tools and case management protocol. It will use evaluation results to identify the promising practices and help coordinate the iterative processes across all communities for development of a promising practices Blueprint that encourages a degree of provincial standardization while allowing for local variation to address the contexts of local communities. The Provincial Working Group will meet on a quarterly basis once testing of common tools (Danger Assessment, MOSAIC, Goal Attainment, and the IRIS Care Platform ) are in place.
4. **Communities of Practice (CoP)** aide in placing attention on those whose voice is not always heard; these include representatives of indigenous; newcomer, immigrant and refugees; and 2SLBGQT communities. The Communities of Practice will provide a forum to share thoughts, ideas and concerns about the implementation, training and development/refinement of the assessment tools, language, perspective, barriers and gaps. The Communities of Practice will aim for monthly meetings.
5. **Blueprint Information Sharing Agreement (ISA) Subcommittee:** with membership from local agencies, shelters, the ISA Subcommittee will prepare the initial draft of the ISA and meet regularly throughout the project to refine the agreement as necessary. It will also identify any systemic barriers to information sharing and review data collection efficacy. Initially the subcommittee will meet weekly to develop the draft ISA, following signatures, the subcommittee will meet quarterly to review the ISA.
6. **Focus Groups:** Those with living or lived experience will be invited to participate in Focus Groups to discuss various elements of the project. They will also be invited to share their thoughts of service delivery and wrap-around services through the developmental evaluation process.

## Information Sharing Authority: *Example follows*

The collection and disclosure of personal, health and case specific information between agencies is a critical component of a successful multi-agency wrap-around service delivery approach. The sharing of personal information, within Community Working Group participants, is essential in achieving successful outcomes in terms of service delivery, agency collaboration, and client support.

This Information Sharing Agreement (ISA) provides authority for agencies to collect and disclose personal and health information to other participants on the basis of necessity, to the extent necessary for client support, to allow for determination of a coordinated, collaborative approach with the client.

This means that each participant will consider what information is essential and therefore necessary for agencies to be able to fulfil their duties and responsibilities. Types of information agencies are likely to need to share to support victims, conduct risk assessments and help keep clients safe would be encompassed within the following definitions of demographic data and personal data, as follows:

* **Demographic Data**: data which relate to a living individual who can be identified from that data or any other information held or likely to be held. This includes: name, pronouns, address, and date of birth, number and age of children.
* **Personal Data**: consists of information concerning details of historical and current abuse, goal plan, case notes, danger/risk assessment score, MOSAIC score, cultural or ethnic origin, religious or other similar beliefs, physical/mental health or condition, substance use, and gender identity - pronouns.

Agencies will be collecting and disclosing personal information with the explicit client consent. A signed consent form for release and receipt of demographic and personal information is required. When a decision is made by one of the agencies to collect and disclose information without consent of the client(s), it will be made with the client(s) safety, as well as the safety of the public, in mind. See Program Controls for more information.

## Dispute Prevention & Resolution (example follows)

Where a dispute arises between agencies in relation to any aspect of this Information Sharing Agreement including day-to-day operations, information sharing, confidentiality, or other matters related to information sharing, the participants agree that the matter will first be referred to the agency in question’s management team, who will make efforts to resolve the matter informally.

If the issue cannot be resolved by management, the agency agrees the matter will be referred to the Blueprint Management Team, for formal resolution. A consensus decision-making model will be used whenever possible.

* All members will be given the opportunity to be heard and engaged throughout the issue resolution process.
* All members must give permission for the decision to move forward.
* Members will be deliberate and mindful in their discussions.
* In cases where unanimous agreement cannot be achieved initially, the following process will be applied to move the group towards consensus:
	+ The discussion may be tabled until the members have more information, time to reflect, or time to check back with their agency. *(Must be cognizant of health and safety situations.)*
	+ A member may abstain from making a decision so that the group may continue.
	+ A minority report can be used to highlight and honour a group that has a different view than the majority.
	+ All members agree to maintain confidentiality regarding discussions held prior to the announcement of a decision.
	+ If consensus cannot be reached, a 75% majority vote of attendees shall prevail.

## Project and Procedure Review Schedule (example follows)

The Name of collaborative initiative will need to support ongoing local change work and facilitate sharing and learning at the provincial working group, in communities, and between communities and the provincial working group. What is learned in local communities and at the provincial working group will be incorporated into the Blueprint. This work will be enhanced by data received from the ongoing developmental evaluation process.

As turnover is high in the sector, the project strategy, structure, and processes must accommodate this. The Project Team will need to assist and advise project and implementation planning so that the project plan supports local change work, provincial learning and sharing, and addresses the need for continuity and sustainability as local project membership changes.

This work will be done on an ongoing basis throughout the project and will form part of the reporting to the Provincial Working Committee and to the individual Working Groups and Communities of Practice.

## Information Sharing Agreement Terms (example follows)

* This Information Sharing Agreement (ISA) will come into force when it is signed and dated and executed by all participating agencies.
* A signed copy shall be kept by each agency. This agreement will remain in force until replaced by another ISA or terminated in accordance with this ISA.
* The participants agree to review this ISA on a quarterly basis.
* This ISA may be amended by written agreement of all participants.
* Any of the agencies to this ISA may terminate participation in this ISA upon provision of thirty (30) days written notice to all other participants, advising of their intention to terminate their participation in this ISA. Upon termination the agency will retain their client files but will be unable to continue use of the IRIS Care Platform information sharing process.
* Except where specifically stated, the terms of this ISA are not intended to be legally binding on any of the agencies or on any related federal, provincial, or municipal government, or not-for-profit agency, in Canada or Alberta.
* Nothing in this agreement replaces or amends any obligation of the participants are bound to or required to perform by operation of law.
* It is the intent of all parties to implement best practices to protect personal information.

# Legislation & Information Management

## Overview of Privacy and Information Sharing in Alberta (example follows)

Federal and provincial laws allow for the collection, use and disclosure of personal information by a variety of public bodies, custodians and private organizations. Generally, consent is required before personal information can be disclosed; however all legislation allows for personal information to be disclosed in certain situations. The following acts allow for the sharing of information:

* + - * Children First Act
			* Child, Youth and Family Enhancement Act (CYFEA)
			* Freedom of Information and Protection of Privacy Act (FOIP)
			* Health Information Protection Act (HIPA)
			* Personal Information Protection Act (PIPA)

The provincial Freedom of Information and Protection of Privacy Act (FOIP) also permits disclosure of the information for a purpose consistent with the original purpose of collection. The collection of personal information must be for a reasonable and authorized purpose and the personal information must be relevant to that purpose. Subject to certain limited exceptions, personal information regarding a victim, alleged perpetrator, or involved family members must not be used or disclosed for purposes other than those identified upon collection unless the person consents to the new use or the disclosure is authorized by law.

Commentary regarding privacy legislation has stated that the *threat to life trumps privacy*. While privacy laws limit situations in which someone’s personal information can be disclosed, they also allow personal information to be disclosed in the public interest[[7]](#footnote-8), or where disclosure will avert or minimize a risk of harm to the health or safety of a minor, or an imminent danger to the health and safety of any person[[8]](#footnote-9).

1

## Information Management

Client information collected in the blueprint project will be held in the agency client files, the agency database and the blueprint data collection app in SharePoint. Access to these Client Files, will be restricted to the agencies who have signed the Blueprint Information Sharing Agreement.

In the event that an agency receives a subpoena request regarding a client who is being, or has been served, each agency shall retain sole responsibility for responding to such a request. The response will be done in accordance with the policies and legislation that guide such requests received by their agency, if the subpoena is addressed to that client’s agency.

Participants shall not disclose personal information about a client, created by another agency or an external body unless required to do so by a court of law.

Client information will be managed in accordance with agency retention schedules.

## Confidentiality

Personal information disclosed by each agency is supplied on a "need to know" basis solely for the purposes of providing collaborative service to the client. All personal information shared by/between agencies, is shared within the bounds of a mutual expectation of confidentiality.

Agencies shall keep all personal information received from each other as part of the Blueprint, securely stored, with access only to be available by those persons employed or authorized by each of the agencies, for the purposes of providing services to the client(s), or otherwise by law Sections 33 to 43 of the FOIP Act of Alberta, and Sections 20, 27 and 34 of the Health Information Act.

While most not for profit agencies do not fall under with FOIP or PIPA except in unique circumstances, all agencies are committed to the best practices for the protection of personal information.

## Information Flow: (example follows)

The following table details the, Blueprint Agencies, their programs and the flow, use and management of information within the Blueprint project (Example provided)

| Agency | Programs( | Information Needed | Source of Information | Information Destination | Information Use | Legislation |
| --- | --- | --- | --- | --- | --- | --- |
| Alberta Council of Women’s Shelters (ACWS)Our Vision we believe in a world free from violence and abuse.Our Mission is to support ACWS members and work together to end domestic violence and abuse.Our Beliefs We believe in empowerment for women and the equal worth of all persons.* We believe in strength of numbers together for a common mission.
* We believe that the issues of violence and abuse are the responsibilities of the entire community including legal, social and political structures.

Our Values* Women’s Equality and Empowerment
* Inclusivity
* Collaboration
* Stewardship
 | The following are list of programs with front-line positions that can participate in the blueprint information sharing framework:**Director of Programs:** this role is responsible for the leadership and oversight of effective services supporting the needs of ACWS across programs and projects and strategic goals.**Data and Member Support:** this role works together with the Director of Programs and Development and Training Coordinator to develop resources that support the work of ACWS members as well as data collection in the form of databases, apps, SharePoint sites and reporting measures in Power BI, or other visualizations. This includes development and deployment of the data collection app to members agreeing to participate within the Blueprint project.**Member Program Development and Training Coordinator:** this role develops, assists and provides training and educational support to members of ACWS and works in tandem with the Director of Programs and Data and Member Support. Trainings can include assessment tools such as Danger Assessment, Goal Attainment, MOSAIC resiliency training, ethical practice and leadership but is guided by the needs of the members. | Administrative SharePoint access to each organization/ agency participating in the use of the data collection app for migration of the app and when necessary for updates or technical support. This access can and should be removed by the agency when work is complete. | The organization/ agency using the data collection app. | The blueprint data collection app in SharePoint, under each participating agencies Microsoft 365 SharePoint environment. A master file of the client that has agreed to share information will be securely stored in a Sequel server that is password protected and has multi-factor identification security. | A client master file stored on a Sequel Server is used to only share information between agencies on clients that have consented. Only when ACWS is needed to deploy technical support will any client information be viewable temporarily and never downloaded to the ACWS SharePoint environment or to an ACWS staff member’s work or personal devices.    | FOIP does not directly apply to not-for-profit agencies and NGOs. grants and contracts require NGOs to comply with the spirit and intent of FOIP and best practices for privacy protection, which ACWS follows.All ACWS staff have to comply with our Oath of Confidentiality and privacy protection policies, with an annual sign off and regular staff training on this topic.  |
| Name of AgencyOur Vision:  Our Mission:  Our Core Values:  | The following are the list of programs with front-line positions that are participating:  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  | . |
|  |  |  |  |  |  | . |

## Program Controls (example follows)

## A Consent-based Approach

Professsionals and agencies needing to share information will obtain explicit written consent or documented verbal consent. A consent-based approach:

* + - * Provides the client with a degree of control over any decisions, in what is often a very dangerous situation;
			* Increases the likelihood of clients engaging with services, maintaining contact and re-contacting them in the future;
			* Increases the likelihood of clients accepting offers of advice, support and protection;
			* Gives professionals and organisations a strong form of protection against any future challenges.

Informed consent must be freely given and should not be:

* + - * Inferred;
			* Provided on the basis of misinformation or misleading statements;
			* Buried in small print or the implications otherwise disguised;
			* Provided under duress; must be freely given and agency services are not contingent upon the client consenting

Clients will be informed at the outset how their personal information will be used, who is responsible for it, how to contact them and who will have access to the information. Also, if relying on consent as a basis to share personal data this must be explicit. Individuals should be made aware of any potential risks of harm or consequences that may come with consenting to this information sharing. Individuals should be provided with clear directions on how to withdraw consent if they so choose.

## Gaining Informed Consent

Informed consent must be “absolutely clear” and based on information provided about:

* + - * the specific detail of the processing;
			* the particular type of data to be processed (or even the specific information);
			* the purposes of the processing;
			* any other aspects of the processing that affect the

Gaining explicit written consent need not be an onerous task and can be done as part of the routine process of initiating contact with clients. When seeking informed explicit consent from a client to share information the following checklist can be used:

* + - * Has the client been informed of the reasons why the data may be shared?
			* Has the client been informed of what information may be shared, when and with whom?
			* Has the client been reasonably informed of the implications of granting consent?
			* Has the client been informed of the right to refuse consent, give partial consent (i.e. allow the sharing of some information) or withdraw it at any time?
			* Have measures been put in place to ensure that the client will be kept up-to-date with the information sharing process in relation to the information?
			* Does client understand they have the right to not provide information?

Clients may have additional needs due to learning difficulties problems with reading and writing, sight or hearing impairments, lack of comprehension of English etc. Each client's needs should be assessed on an individual basis and additional steps taken such as the publication of information in a range of locally used languages, use of interpreters, and/or involvement of advocates and representatives to ensure that clients can give informed explicit consent. Such measures will be familiar to many agencies as part of their general provision of a client- centred and culturally sensitive service.

## What to do if consent is refused

If a consent-based approach is initially pursued and consent is refused, practitioners should not, unless it is unavoidable, seek to override this. In such circumstances expert advice should be sought. If there is evidence to suggest there will be a need to share information without consent then it is good practice to pursue a non-consent approach from the outset. This makes it especially important for practitioners to make a careful assessment at the outset whether consent should be sought or whether the circumstances are such that the consent-based approach needs to be set aside.

Situations where consent-based approach may be overridden:

* + - * Where the vital interest of the client is at risk, and where the sharing is necessary for matters of life and death or for the prevention of serious harm to the client.
			* The public interest in safeguarding a child’s welfare overrides the need to keep the information confidential; where there is a need to share confidential information to protect a child’s welfare without consent, staff should report this to Children Family Services; or
			* Disclosure is required under court order or other legal obligation.

When a decision is made to share personal and or health information without consent, the decision must be:

* + - * Reached on a case-by-case basis
			* Based on necessity to disclose
			* Be properly documented at the time of disclosure, including the decision to disclose, and what information was disclosed.

## Benefits of Sharing Information (example follows)

## Benefits to Clients:

Responsible information sharing in an integrated family violence system is a critical mechanism to:

* + - * Keep survivors safe and holding perpetrators to account.
			* Increase client’s sense of confidence that their situation is understood and is being managed across a range of service providers, without having to repeat personal and sensitive information.
			* Enable timely action to be taken to protect clients and children from further abuse and mitigate eminent danger.
			* Enable a comprehensive risk identification and safety planning based on a full account of the facts and circumstances of each client’s situation.
			* Offer the right sort and combination of advice, support and advocacy to be offered at the right time based on a full and accurate account of the client's needs and history, including other service contact and use.
			* Improve the ability to offer wrap-around services and coordination of services for the client.
			* Reduce wait times as agencies coordinate services and programs.
			* Avoid the added distress of having to repeat details of their history or experience of DV and other circumstances each time they encounter a different service.

## Benefits to Agencies:

* + - * Agencies benefit from increased ability to share information:
			* Enables earlier intervention and prevention strategies to be implemented by agencies.
			* Support effective and enhanced assessment and management of family violence risk through information sharing between agencies.
			* Enhances client protection and safety strategies.
			* Enhances case management and coordination, as well as, providing services with clearer roles and expectations for service provision.
			* Provides for fully informed and cohesive service delivery; recognizes commonalities and amplifies advocacy.
			* Increases agency collaboration and service coordination across agencies.
			* Creates more efficient flow of information, coordination of services and thereby efficient use of resources.
			* Avoids duplication of effort, especially non-value added effort (e.g. in record taking, service provision etc.)
			* Increases confidence that services are provided in a comprehensive, safe, high quality manner; within the provisions of the law.
			* Enhance reputation for professionalism and credibility with clients and other agencies by demonstrating their competence in this area.

# Risk Management

## Risks of Sharing Information

To individuals/families

* + - * Spouse identifying and targeting the member.
			* Potential breach of confidentially and privacy.
			* Accidental ‘outing’ or revealing other personal data.
			* Clients may feel they have lost control over their story and information.
			* An agency’s false perception of the client based on historical patterns; may impact future services received

To Agencies

* + - * With access to information comes the responsibility for interpreting and using the information wisely; requires an investment in additional staff training.
			* The amount of information shared may turn out to be insufficient or too much for the purposes necessary.
			* May inadvertently share information with the wrong agency / staff person.
			* Unduly influencing another agency by sharing client’s past historical patterns
			* The Client withdraws consent or provides what turns out to be false information.
			* Potential technical issues – accidently risking a privacy breach (i.e. hacked).

## Risks of Not Sharing Information

To individuals/families

* + - * Inadvertently places client in a position of higher or escalating risk.
			* Children not included in a restraining order or clear parenting order
			* Limits services client may access from other agencies; increases wait times.
			* Traumatizing to client if they have to share information multiple times or cannot find the right services based on a lack of information
			* Missing information or pieces of the puzzle that are not shared can impact outcomes.

To Agencies

* + - * A biased agency perception of the client.
			* Damage to agency reputation; labeled as uncooperative, unprofessional or not a team player.
			* Duplication of services leads to burnout and stress; increases staff workload (i.e. phone tag);
			* Lack of awareness of what services client is receiving from other agencies – impedes ability to coordinate wrap-around services.
			* Serious injury or death of the client due to a failure of the agency to share appropriate information for the client’s safety.
			* Burnout and vicarious trauma to staff who are unable to support he client due to a lack of information sharing and collaboration.

## Outcome Goals and Indicators (example follows)

## Impact Framework

**As a result of the Blueprint…**

## ***Population:* Community partners/service providers**

|  |
| --- |
| Impact 1 – Service providers grow their capability to inclusively and intersectionally engage all clients.  |
| Dimensions* Value all clients’ needs, desires, and stories
* Consider and support clients’ intersectional identities in all aspects of their work
* Engage clients relationally
 |
| **Domain** | **Quantitative Indicators** | **Qualitative Indicators** |
| Mental(Know à Believe) | 1. Gain greater understanding of clients’ cultural, gender, sexual, and ethnic needs
2. Know community resources that will be appropriate for each client
 | 1. Believe that every client’s story is sacred
2. Recognize the importance of inclusion and intersectionality in all aspects of their work
 |
| Behavioral(Do à Become) | 1. Take time to learn clients’ specific needs
2. Revise policies, procedures, and tools to be more inclusive
3. Bring in resources to support clients rather than sending them out to other service providers
 | 1. Advocate and educate on behalf of clients
2. Ensure the client is centered in all policies, procedures and practices
3. Engage clients in a relational rather than transactional manner
 |
| Emotional(Feel à Love) | 1. Feel more comfortable engaging with all clients
2. Feel responsible for ensuring clients’ intersectional identities are respected and considered in all services
 | 1. Dedicated to continually learning from clients and adapting to most effectively serve them
2. Committed to serving all clients regardless of their unique circumstances and intersectional identities
 |

|  |
| --- |
| Impact 2 – Service providers embrace client-centered collaboration.  |
| Dimensions* Service providers become a one-stop shop through collaborating with other organizations to meet client needs
* Share information and standardize tools to streamline client experience
* Adopt a multi-disciplinary team approach to client support
* Shift from program-centric to client-centric
 |
| **Domain** | **Quantitative Indicators** | **Qualitative Indicators** |
| Mental(Know à Believe) | 1. Know other service providers in the community, what they’re doing and how they’re doing it
2. Understand the information-sharing framework – who’s gathering information, who’s sharing it, how, and why
3. Know how to effectively collaborate with other service providers
4. Identify those who are underserved
 | 1. Value collaboration as a strategy for serving clients
2. Shift their perspective from program-centric to client-centric
 |
| Behavioral(Do à Become) | 1. Share information with other service providers
2. Create standardized tools to streamline information sharing
 | 1. Develop a multi-disciplinary team approach to client support
2. Develop inclusive and intersectional policies and practices within and between organizations
 |
| Emotional(Feel à Love) | 1. Feel eager to collaborate in new ways
2. Feel more comfortable with collaboration
 | 1. Committed to disrupting the status quo in service to their clients
 |

## ***Population:* Sector leaders**

|  |
| --- |
| Impact 3 – Sector leaders develop adaptable, innovative learning organizations.  |
| Dimensions* Strengthen their organization’s policies and procedures
* Focus on evaluation and learning to continuously improve their organization
* Build a culture of learning and innovation
* Embrace change in service to clients
 |
| **Domain** | **Quantitative Indicators** | **Qualitative Indicators** |
| Mental(Know à Believe) | 1. Aware of their own and their organization’s “blind spots”
2. Know best practices for evaluation and learning within organizations
3. Understand the diverse needs of their staff and clients
 | 1. Value evaluation data as a tool for organizational learning and growth
2. Believe in the strategic importance of being nimble and adaptable
 |
| Behavioral(Do à Become) | 1. Adopt practices of regular reflection and evaluation
2. Regularly connect with staff and clients
 | 1. Build a culture of learning and innovation
2. Proactively plan for adaptation and innovation
3. Invest in building the capacity of their organizations to be responsive to emergent needs and projects
 |
| Emotional(Feel à Love) | 1. Feel more confident in their organization’s ability to adapt to changing needs
2. Feel less fearful of change
 | 1. Dedicated to continuously improving services
 |

|  |
| --- |
| Impact 4 – Sector leaders build a collaborative network of service providers.  |
| Dimensions* Believe that sector-wide and cross-sector collaboration is essential to effectively serving clients
* Engage with other sector leaders to create a client-centered system
* Advocate on behalf of clients and keep their voices centered
* Develop policies and practices to share information ensure effective collaboration
 |
| **Domain** | **Quantitative Indicators** | **Qualitative Indicators** |
| Mental(Know à Believe) | 1. Understand best practices for collaboration
2. Recognize that their organization can’t meet all of their clients’ needs alone
 | 1. Believe in working inclusively to balance the needs of women and children and those who have been most marginalized
2. Believe in the importance of sector-wide and cross-sector collaboration
3. Shift their mindset from competitive to collaborative
 |
| Behavioral(Do à Become) | 1. Regularly meet with other sector leaders to reflect and evaluate how the system is serving clients
2. Implement policies that support collaboration
 | 1. Become advocates for clients within the network and community
2. Develop clear, transparent policies and practices for sharing information and service provision across the system
3. Shift from a systems navigation approach to a client-centric system
 |
| Emotional(Feel à Love) | 1. Excited to collaborate in service to clients
2. Less concerned about their organization’s role
 | 1. Dedicated to ensuring clients’ voices are centered in all aspects of their work
 |

## ***Population:* Clients**

|  |
| --- |
| Impact 5 – Clients engage systems of support. |
| Dimensions* See themselves reflected in the services they receive
* Develop strong formal and informal supports
* Able to achieve their goals for themselves and their families
* Believe they are worthy to receive services and support
 |
| **Domain** | **Quantitative Indicators** | **Qualitative Indicators** |
| Mental(Know à Believe) | 1. Know who their case manager is and how s/he can support them
2. Know the services available to them
3. Know other people they can turn to for support
 | 1. Believe their needs and desires are important
2. Believe that their case manager “gets” them
3. Optimistic about their future
 |
| Behavioral(Do à Become) | 1. Express their needs and desires
2. Ask for help
3. Set goals for themselves and their families
4. Take advantage of wraparound services and other supportive opportunities
 | 1. Develop strong, supportive relationships with their case manager and other natural supports
2. Become goal-oriented
3. Proactively reach out for support when needed
 |
| Emotional(Feel à Love) | 1. Feel respected and valued
2. Feel supported
3. Less worried about how their needs will be met
4. Feel more confident that they can live independently and safely
 | 1. Committed to achieving their goals
2. Dedicated to keeping themselves and their family safe and healthy
 |

|  |
| --- |
| Impact 6 – Clients are safer.  |
| Dimensions* Create a safety plan
* Believe in their ability to keep themselves and their family safe
* Become more independent and self-sufficient
* Maintain a system of support and reach out when needed
 |
| **Domain** | **Quantitative Indicators** | **Qualitative Indicators** |
| Mental(Know à Believe) | 1. Know how to develop a safety plan
2. Know who they can go to when they need support
3. Learn how to identify risky situations
 | 1. Believe that they have what it takes to keep themselves and their family safe
2. Believe they have the support they need to overcome challenges
3. See beyond their current reality and envision new possibilities for their future
 |
| Behavioral(Do à Become) | 1. Share their experience with their case manager
2. Create a safety plan
3. Take steps to improve their safety
 | 1. Create an environment for themselves and their families that minimizes risk
2. Motivated to become more self-sufficient
3. Proactively reach out for support when needed
 |
| Emotional(Feel à Love) | 1. Feel more confident that they can keep themselves and their family safer
2. Feel more comfortable reaching out for help
3. Reduced fear and anxiety
 | 1. Dedicated to keeping themselves and their family safe and healthy
 |

# Common Terms / Definitions

|  |  |
| --- | --- |
| Term | Definition |
|

|  |  |
| --- | --- |
| Consent |  |

 | Permission for something to happen, or agreement to do something, after being provided all relevant information. Consent may be written or in documented verbal form. |
| Client  | For the purposes of the ISA, a client means, any member of the community fleeing from domestic violence (including a child, their legal guardian, or non-offending family member). |
| Collaboration | Means two or more agencies working together to realize shared goals. |
| IRIS Care Platform | To aid in wrap-around services that are client centered and trauma-informed, and assist organizations in safely sharing client information to improve on services provided this SharePoint App and site will aid in the sharing of information between agencies who have signed the information sharing agreement. |
| Information Sharing Agreement | A multilateral agreement between two or more parties, expressing a convergence of will, and indicating a common line of action. An ISA is not a legally enforceable agreement. |
| Demographic Data | Means information that can be used on its own, or with other information to identity, contact or locate a single person, or identify an individual in context. This includes contact information, recorded information and verbal information. Data which relate to a living individual who can be identified from that data or any other information held or likely to be held. It also includes any expression of opinion about the individual and any indications of the intentions of any person in respect to the individual. |
| Personal Data | Personal data which consists of information concerning racial or ethnic origin, political opinions, religious or similar beliefs, physical/mental health or condition, sexual or gender life, alleged or committed offences, proceedings, disposal or sentence concerning an alleged or committed offences. |
|  |  |

# Signature Section

By signing this document, participating members of *Grande Prairie Blueprint Community Working Group* express their commitment to working collaboratively in implementing this Information Sharing Approach to Safety from Domestic Violence.

|  |  |  |
| --- | --- | --- |
| **Name**Agency |  | **Name**Agency |
| **Name**Agency |  | **Name**Agency |
| **Name**Agency |  | **Name**Agency |
| **Name**Agency |  | **Name**Agency

|  |  |
| --- | --- |
|  |  |
|  |  |

 |
| **Name**Agency |  | **Name**Agency |
| **Name**Agency |  | **Name**Agency |
| **Name**Agency |  |  |

## Appendix A: SharePoint and App Data Fields (example follows)

|  |  |
| --- | --- |
| QUESTIONS | DESCRIPTION |
| Intake |  |
| Client Name | Pulls from a look up field |
| Name of Staff Filling Out Form | Can pull from a look up field |
| Type of Program | Residential, Outreach, specifies between Emergency or Second Stage |
| Type of Program if Other | Those different than above |
| Region | Region zones |
| Do you have ID? | Yes or No |
| Type(s) of ID: |  |
| Intake - Admission Information |  |
| Client Name | Pulls from a look up field |
| Admission Date | Date admitted to the program |
| Type of Client | Selection based on what the client is experiencing which has caused them to seek help, for example victim of abuse, victim of sexual assault |
| Family Composition | Single person or family |
| Are there non-admitted dependents? | Yes or No |
| Number of non-admitted dependent children? | Numerical |
| Is the woman pregnant | Yes or No |
| Due Date if pregnant | Date |
| Clients residence at admission | In Alberta, other province or outside of Canada |
| Transportation to shelter | How they arrived at the shelter |
| How far did you travel? | In distance |
| Abuser (partner/spouse/other) descriptor | Free field to write description |
| Referral Source | Covers different types of supports/agencies/services that could havereferred client |
| Client withdrew request for admission | Yes or No |
| Reason client withdrew request for admission | Free field to explain reason(s) |
| Intake - Abuse History |  |
| Client Name | Pulls from a look up field |
| Has client stayed in shelter in the past? | Yes/ No/ Unknown |
| Type of shelter? (DV/Emerg, Second Stage, Third Stage, Transitional, Homeless, and/or Youth) |  |
| Did client return to the same relationship? | Yes/ No/ Unknown |
| Primary abuser gender | Selection of options |
| Primary abuser if intimate partner | Selection of relationship types |
| Primary abuser if family | Selection of family member types |
| How many abusers were there - if partner/ex-partner? | Numerical |
| How many abusers were there - if family? | Numerical |
| Were there other abusers? | Yes or No |
| How many other abusers were there? | Numerical |
| Comments on abusers | Free field to write comments |
| Type(s) of abuse experienced leading to admissions | Selection of types of abuse |
| Abuse in adulthood before this admission | Yes or No |
| Type(s) of abuse in adulthood before this admission | Selection of types of abuse |
| Abuse experienced/witnessed as a child? | Yes or No |
| Type(s) of abuse experienced/witnessed as a child | Selection of types of abuse |
| Any physical injuries received as a result of abuse | Yes/ No/ Unknown |
| Self-reported physical injuries received from abuse | Selection of types of injuries |
| Consulted a health service professional about injury | Yes/ No/ Unknown |
| If consulted a health service provider about injury-describe | Free field to describe |
| Was client hospitalized as a result of this abuse? | Yes/ No/ Unknown |
| Days hospitalized | Numerical |
| Abuse of others witnessed? | Yes or No |
| Type(s) of abuse witnessed leading to admission | Selection of types of abuse |
| Were police services needed during events leading up to stay? | Yes or No |
| Were police services contacted during events leading up tostay? | Yes or No |
| Did police respond? | Yes or No |
| Type(s) of police services provided | Selection of types of police services |
| Has abusive partner threatened to lie to authorities | Yes/ No/ Unknown |
|  |  |
| Intake - Demographics |  |
| Client Name | Pulls from a look up field |
| Current marital status | Selection of relationship types |
| Does client self-identify as indigenous? | Yes or No |
| Indigenous Status | Selection of types of status |
| If client is not indigenous, was client born in Canada? | Yes/ No/ Unknown/ Chose not to answer |
| If client was not born in Canada, length of time in Canada | Selection of timeframes |
| Date of arrival in Canada | Date |
| Number of years in Canada | Selection of timeframes |
| Immigration status | Selection of types of status |
| Country immigrated from | Selection of countries |
| Preferred language | Selection of languages |
| Is a translator required? | Yes or No |
| Is a translator available? | Yes or No |
|  |  |
| Intake - Health |  |
| Client Name | Pulls from a look up field |
| Self-reported physical health concerns at time of intake | Yes or No |
| Type(s) of self-reported physical health issues | Selection of types of physical health concerns |
| Is client receiving support to address physical concerns? | Yes or No |
| Does client require support from program to address physicalconcerns? | Yes or No |
| What kind of support is needed to address physical concerns | Selection of types of supports |
| Does client have a self-reported physical disability? | Yes/ No/ Unknown |
| Any self-reported cognitive/mental health concerns? | Yes or No |
| Any self-reported cognitive/mental health disabilities? | Yes or No |
| Type(s) of self-reported cognitive/ mental health issues | Selection of types of cognitive or mental health concerns |
| Is client receiving assistance/support to address mental healthconcerns? | Yes or No |
| Is support from the program needed to address mental health? | Yes or No |
| What kind of support is needed to address mental healthconcerns | Selection of types of supports |
| Suicide ideation/concerns | Selection of types of concerns/ suicide attempts |
| Suicide risk assessment completed? | Yes or No |
| Suicide risk assessment date completed | Date |
| Is the client on prescribed medication? | Yes or No |
| Does client need to see a doctor about getting medication? | Yes or No |
| Does client have concerns with substance use/ addictivebehaviors? | Yes or No |
| Type(s) of substances used/ addictive behaviors | Selection of types of substances or behaviors |
| Is client currently receiving assistance to address addiction? | Yes or No |
| Is client part of a monitored opioid agonist therapy (methadone or sub-oxone) program? |  |
| Support needed to address addiction concerns | Yes or No |
| What kind of support is needed to address addiction concerns | Selection of types of supports |

|  |  |
| --- | --- |
| Intake - Stability factors |  |
| Client Name | Pulls from a look up field |
| Employment status | Selection of types of employment status |
| Highest level of education completed | Selection of education levels |
| Identified concerns with reading, writing or numeracy |  |
| Primary source of income | Selection of income sources |
| Individuals gross annual income | Selection of income levels |
| Individuals gross monthly income | Selection of income levels |
| Partner's gross annual income | Selection of income levels |
| Does client hold responsibility for partner's debt? | Yes or No |
| Partner's debt amount | Free field |
| Describe clients self-reported financial situation at intake | Selection of ranges regarding need for assistance or not |
| Family law issues requiring legal support identified | Selection of types of family law issues |
| Protection order client is seeking to obtain at time of intake | Selection of types of protection orders |
| Protection orders in place at time of intake | Selection of types of protection orders |
| Immigration issues requiring legal support | Selection of types of immigration issues |
| Other legal issues requiring support | Selection of legal issues |
| Living arrangements prior to admission | Selection of types of living arrangements |
| Number of times changed housing in the year prior to intake | Numerical |
| Types of natural / informal supports? (Friends, family, neighbours, employers, work colleagues, support group, self-care, community groups, faith-based, child-care, other) |  |
| Self-care (exercise, faith-based, hobbies, peer supports, family supports, other) |  |
| Access to child care  |  |
| Discharge |  |
| Client Name | Pulls from a look up field |
| Type of Program | Residential, Outreach, specifies between Emergency or Second Stage |
| Discharge Date | Date |
| Reason for Discharge | Selection of reasons for discharge (Chose to leave, was asked to leave or other) |
| If asked to leave or other, please specify reason |  |
| Reason if chose to leave | Selection of reasons (completed the program, found safe accommodationelsewhere etc.) |
| Were dependents discharged at the same time? | Yes or No |
| Living arrangements at time of discharge? | Selection of types of living arrangements |
| Reasons if returning to abuser | Selection of reasons (financial, family pressure, has hope for therelationship, unable to find housing etc.) |
| Type of housing at discharge | Selection of types (transitional, stable, short term/shelter etc.) |
| Was client seeking stable housing? | Yes/ No/ Unknown |
| Was stable housing available to the client? | Yes/ No/ Unknown |
| Was client seeking transitional housing? | Yes/ No/ Unknown |
| Was transitional housing available to the client? | Yes/ No/ Unknown |
| Sources of income expected after discharge | Selection of income sources |
| Individuals gross income expected after discharge | Selection of income levels |
| Individuals gross monthly income expected after discharge | Selection of income levels |
| Describe clients self-reported financial situation at time ofdischarge | Selection of ranges regarding need for assistance or not |
| Type of services provided to client | Selection of types of services a shelter or agency has provided |
| Referrals Made | Selection of types of referrals made at discharge if provided |
| Protection orders obtained in the course of services | Selection of types of protection orders |
| Discharge comments | Free field |
|  |  |

|  |  |
| --- | --- |
| Case Notes |  |
| Client Name | Pulls from a look up field |
| Date | Date |
| Type of Program | Residential, Outreach, specifies between Emergency or Second Stage |
| Type of Note | Selection of types of notes (direct contact with client, indirect on behalf ofclient) |
| Comments | Free field |
|  |  |
| Client Daily Log |  |
| Client Name | Pulls from a look up field |
| Comments | Free field |
| Attachments | Can attach documents |

# Appendix B.1: Danger Assessment

Jacquelyn C. Campbell, Ph.D., R.N. Copyright, 2003; update 2019; www.dangerassessment.com

Several risk factors have been associated with increased risk of homicides (murders) of women and men in violent relationships. We cannot predict what will happen in your case, but we would like you to be aware of the danger of homicide in situations of abuse and for you to see how many of the risk factors apply to your situation.

Using the calendar, please mark the approximate dates during the past year when you were abused by your partner or ex-partner. Write on that date how bad the incident was according to the following scale:

1. Slapping, pushing; no injuries and/or lasting pain

2. Punching, kicking; bruises, cuts, and/or continuing pain

3. “Beating up”; severe contusions, burns, broken bones

4. Threat to use weapon; head injury, internal injury, permanent injury, miscarriage or choking\* (use a © in the date to indicate choking/strangulation/cut off your breathing- example 4©)

5. Use of weapon; wounds from weapon

(If **any** of the descriptions for the higher number apply, use the higher number.)

Mark **Yes** or **No** for each of the following. ("He" refers to your husband, partner, ex-husband, expartner,

or whoever is currently physically hurting you.)

\_\_\_\_\_1. Has the physical violence increased in severity or frequency over the past year?

\_\_\_\_\_2. Does he own a gun?

\_\_\_\_\_3. Have you left him after living together during the past year?

\_\_\_\_\_3a. (If you have *never* lived with him, check here: \_\_)

\_\_\_\_\_4. Is he unemployed?

\_\_\_\_\_5. Has he ever used a weapon against you or threatened you with a lethal weapon? (If yes,was the weapon a gun? Check here: \_\_)

\_\_\_\_\_6. Does he threaten to kill you?

\_\_\_\_\_7. Has he avoided being arrested for domestic violence?

\_\_\_\_\_8. Do you have a child that is not his?

\_\_\_\_\_9. Has he ever forced you to have sex when you did not wish to do so?

\_\_\_\_\_10. Does he ever try to choke/strangle you or cut off your breathing?

\_\_\_\_\_10a. (If yes, has he done it more than once, or did it make you pass out or black out or make you dizzy? check here: \_\_)

\_\_\_\_\_11. Does he use illegal drugs? By drugs, I mean “uppers” or amphetamines, “meth”, speed, angel dust, cocaine, “crack”, street drugs or mixtures.

\_\_\_\_\_12. Is he an alcoholic or problem drinker?

\_\_\_\_\_13. Does he control most or all of your daily activities? For instance, does he tell you who you can be friends with, when you can see your family, how much money you can use, or when you can take the car? (If he tries, but you do not let him, check here: \_\_)

\_\_\_\_\_14. Is he violently and constantly jealous of you? (For instance, does he say: “If I can’t have you, no one can.”)

\_\_\_\_\_15. Have you ever been beaten by him while you were pregnant? (If you have never been pregnant by him, check here: \_\_)

\_\_\_\_\_16. Has he ever threatened or tried to commit suicide?

\_\_\_\_\_17. Does he threaten to harm your children?

\_\_\_\_\_18. Do you believe he is capable of killing you?

\_\_\_\_\_19. Does he follow or spy on you, leave threatening notes or messages, destroy your property, or call you when you don’t want him to?

\_\_\_\_\_20. Have you ever threatened or tried to commit suicide?

\_\_\_\_\_Total “Yes” Answers

**Thank you.**

**Please talk to your nurse, advocate, or counselor about what the Danger Assessment means in your situation.**

# Appendix B.2: Danger Assessment – Walking the Path Together

# Appendix B.3: Danger Assessment – Immigrant Women



# Appendix B.4: Danger Assessment – Same Sex



# Appendix C: Measure of Survivor Abuse Impacts and Complexities (MOSAIC)



## Appendix D: Goal Attainment (example follows)

**GOAL ATTAINMENT**

The second stage shelters made the decision to use a goal attainment scale as one measure of women’s progress while residents of second stage shelters.

Counselors and each individual woman participate together in setting and evaluating goals. Women are encouraged and supported to decide which problems they want to address and how they want to address them. Although goal setting is client driven, setting goals is always a shared process with the counsellor providing guidance and support.

While it is crucial to maintain focus on the agreed upon goals that are set at an initial assessment, it is important that goals are regularly assessed to determine progress and also to determine if there are additional goals that the woman wants to set.

The initial assessment involves conceptualization of the problems a woman identifies, collaborative goal definition and an agreed upon plan of action to begin to work towards achieving the identified goals. Goal setting provides a solid foundation for the focus of work with each individual woman. The action plan provides guidance for the woman to take small steps towards achieving her goals. It is important to revisit the goals and if necessary make modifications to the goals throughout a woman’s stay in Second Stage.

As agreed upon by the shelter directors all women residing in second stage shelters are expected to set and work on goals in the areas of safety, accommodation and community networks. The following issues were identified as being important for women to address in their move towards greater safety, self-efficacy and independence.

1. **Women’s safety:** Women’s safety is the most important work of shelters and working with individual women to ensure that each has an understanding of her individual safety risks and develops a plan to decrease risks of violence and increase safety is essential. Safety will be very different for individual women depending on their individual circumstances. Safety goals can vary from setting a goal of being able to travel safely to a place of employment or school, safety when exchanging children with an ex-partner, obtaining a restraining order.
2. **Child safety**: The safety of children is also essential to the work of shelters. Each mom is supported to evaluate the safety of her children and to establish a goal(s) to increase their safety. Examples of safety goals focusing on children might include talking to children about safety when on a visit with their father, obtaining sole custody, securing a restraining order or EPO that includes the children.
3. **Housing/accommodation**: Because women are limited in their stay at a Second Stage shelter all women are expected to establish a goal of obtaining follow-up accommodation. The specifics of this goal will vary for individual women. Some women may have a goal of buying their own home, some may have a goal of securing a rental home in a specific area, some may have a goal of securing subsidized housing, others may have a goal of relocating outside of Calgary.
4. **Financial and income:** Some women in second stage may have a stable source of income and feel comfortable with their financial situation. Many will likely need to secure a reliable source of income which may include any of the following: applying for Alberta Works, Maintenance, Child Tax Credit, AISH, EI. Other woman may want to work on a goal of setting a budget and a plan on how to keep the budget. Others may have a goal of establishing a savings plan.
5. **Basic Needs/Identification:** Some women in second stage may want to set goals related to acquiring furniture or other household items for their apartments. Others may set a goal of knowing the resources necessary to assist with specific basic needs. For example, setting a goal to find out how to access the food bank or become part of a Good Food Box program or Collective Kitchen.
6. **Legal issues**: There are a variety of legal issues that women accessing second stage shelters may want to address. For example, obtaining a separation or divorce agreement, securing a maintenance order, establishing a parenting order. Others may have immigration issues that they want to seek legal advice about. Some women may want to pursue an EPO, or a Restraining Order.
7. **Community supports/social networks**: Women living with an abusive partner are often isolated and have few community supports. Some women may have goals related to increasing their formal and informal supports within the community. Some may set a goal to join a group that they are interested in- a mom and tots group, an craft group.
8. **Relationships:** Some women may set goals that focus on improving relationships with family members or friends. Some may want to work on a goal of establishing a co-parenting relationship with their ex-partners.
9. **Self-care and living skills**: Goals related to improving one’s ability to care for oneself may be important for some women. For some women they have been so busy surviving they have not learned the importance of taking care of themselves and all of their various needs. Some may set goals that relate to creating a better balance in their lives- taking care of their physical, emotional, spiritual and mental needs.
10. **Employment/education**: While living in a stable environment some women may set goals related to securing full or part time employment. Others may set goals related to upgrading, attending night school, on-line learning, attending university for example.
11. **Child care**: If women do have goals of attending school or securing employment then it is likely that they will also have goals that focus on securing safe, affordable childcare. Others may set a goal to find childcare that will allow them to pursue some of their interests or to have time to themselves for counseling or to attend to legal issues for example.
12. **Parenting:** Parenting while living in an abusive relationship can be very challenging. Some women may set goals that relate to their roles as mothers. They may want to learn to discipline in a healthy way, they may want to have a greater understanding of their child’s development.
13. **Physical health:** Women living with abuse may have a variety of health issues related to the stress that they were living under. Some may set goals that focus on improving their physical health. Some may want to find a family doctor that is supportive and knowledgeable about family violence. Others may have neglected chronic health issues that they now want to attend to.
14. **Emotional and mental health: goal to deal with trauma:** Living with abuse can have a detrimental impact on a woman’s mental health. Some women may be experiencing symptoms of trauma and now that they are living in a safe environment set a goal to deal with their past traumas. Others may be experiencing depression, suicidal ideation, or anxiety and set goals to work on these issues.
15. **Woman’s wellbeing:** Women may also set goals that are not specific to one area of their lives but are focused on their overall wellbeing.
16. **Child’s wellbeing:** Children are impacted by domestic abuse and moms may set goals that focus on their child(ren)’s well-being. Some moms may have a goal of finding a play therapist to work with their children, others may be interested in having their children participate in a group to learn how to express emotions.
17. **Spiritual health:** Some women may set goals of finding a faith community to become a part of; others may want to set goals of finding a way to reconnect with past cultural/spiritual practices that were not supported in their relationships.
18. **Managing addictions:** While living in the safe, secure environment of second stage some women may want to set goals to address addictions. Some may want to set a goal of getting into a residential treatment program, others may set a goal of working with an addiction counsellor, others may set a goal of attending a 12 Step program.
19. **Community resources:** Gaining knowledge and understanding of community resources may be a goal area that many women may be interested in pursuing.
20. **Other:** women may have goals that do not fit in any of the above categories.

**Recommended process for supporting women to set goals and establish a plan of action:**

Within the first month of a woman’s residency counsellor meets with a woman to support her to establish the goals that she wants to work on while residing at the shelter. It may be helpful to have a conversation with a woman about what she sees as areas in her life that she wants to change. Sharing the list of the general areas identified above may assist her to think about areas of her life she would like to work on. It is important for her to know that there is an expectation while living at the shelter for her to work on safety, accommodation and community networking goals.

Once these initial goals are decided upon it is important that each woman be supported to develop plans of action involving small steps to enable her to work towards her larger overall goals.

The goals are then reviewed after approximately 3 months and then again close to the time that a woman is planning to move out of second stage. For shelters providing accommodation up to a year goals should be reviewed after 9 months and again near her leaving date from the shelter.

Goals may be changed or added to during the duration of a woman’s stay in the shelter. When reviewing the goals that have been set it is important to encourage women to assess their own progress in working towards the overall goals.

The following scale is to be used:

1=Little or no progress,

2= Limited progress,

3=Some progress,

4=Good progress,

5= Complete

The Goal Attainment Activity will be put into Outcome Tracker. You will be able to select from one of the following to indicate when the review of the goals was completed.

* Initial goal setting (within the first month)
* First Goal Evaluation (3 months)
* Second Goal Evaluation (6 months or just prior to departure)
* Third Goal Evaluation (9 months or just prior to departure)
* Fourth Goal Evaluation (12 months or just prior to departure)

Some woman may work very hard to achieve a goal and still not make progress due to service barriers. For example, a woman may set the goal of obtaining full custody of her children in order to ensure their safety. She may do everything in her action plan and not be successful because the court awarded joint custody to both parents.

The question: Unable to Achieve Goal due to Service Barriers will also be included.

# Appendix E: CONSENT FORM

CLIENT CONSENT TO RELEASE INFORMATION FORM

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, presently requesting and/or receiving services from one or more of the following agencies hereby consent to the exchange of relevant information between the following agencies and their employees, on an as needed basis. I understand that such information will be exchanged by the appropriate personnel within the following agencies and such information will be held in confidence as per federal and provincial privacy laws. The agencies listed below have all signed the Information Sharing Agreement and will abide by the same level of confidentiality, privacy and informed consent. They are as follows:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Agency / Department** | **Client Initials** | **Date** | **Staff Initials** | **Purpose** | **\*Share Type** |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |   |   |   |  |   |
|  |   |   |   |  |   |
|  |   |   |   |  |   |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |   |   |   |  |   |
|  |  |  |  |  |  |
|  |   |   |   |  |   |
|  |   |   |   |  |   |
|  |  |  |  |  |  |

Share type: 1 – Demographic Data 2 – Personal Data (includes all info)

I understand that I have the right to withhold, give and revoke such consent at any time. I further understand that such releases of information will cease to be valid 30 days after discharge or immediately upon revocation, whichever comes first.

DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ STAFF Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PROGRAM PARTICIPANT Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ AGENCY\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Measure of Survivor Abuse Impacts and Complexities [↑](#footnote-ref-2)
2. For additional references regarding barriers related to risk assessment please see: <https://acws.ca/wp-content/uploads/2021/12/2016-09-30_KWS_RiskAssessmentBrief.pdf> [↑](#footnote-ref-3)
3. For a list of references please see <https://acws.ca/wp-content/uploads/2021/12/2016-09-30_KWS_CoordinationCollectiveImpact_Brief.pdf> [↑](#footnote-ref-4)
4. Government of Alberta (2012). Family Violence Hurts Everyone: A Framework to End Family Violence in Alberta , retrieved from <http://www.humanservices.alberta.ca/documents/family-violence-hurts-everyone.pdf> [↑](#footnote-ref-5)
5. For a list of references please see <https://acws.ca/wp-content/uploads/2021/12/2016-09-30_KWS_DiverseWomenBrief.pdf> and <https://acws.ca/wp-content/uploads/2021/12/2016-09-30_KWS_IndigenousWomen_Brief.pdf> [↑](#footnote-ref-6)
6. Capacity here defined as having needed information about gender-based services and root causes of violence, structures in place to accommodate cultural shift towards gender equality, as well as commitment and willingness on the part of the decision-makers to support this shift within their organizations. [↑](#footnote-ref-7)
7. FOIP s. 32; Health Information Act (HIA) s. 37.3; Privacy Act s. 8(2)(m) [↑](#footnote-ref-8)
8. FOIP s. 40(ee); HIA s. 35(m) [↑](#footnote-ref-9)