



Caring for Child Survivors of Sexual Abuse

Guidelines for health and psychosocial service
providers in humanitarian settings

First Edition



INTERNATIONAL RESCUE COMMITTEE

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For more information about the Caring for Child Survivor's Resources please contact the IRC Women's Protection and Empowerment Technical Unit at info@rescue.org. To download the CCS Guidelines electronically, please go to www.gbvresponders.org.

BILL & MELINDA
GATES *foundation*

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The Caring for Child Survivors (CCS) of Sexual Abuse Guidelines were developed to respond to the gap in global guidance for health and psychosocial staff providing care and treatment to child survivors of sexual abuse in humanitarian setting. The CCS Guidelines are based on global research and evidenced-based field practice, and bring a much-needed fresh and practical approach to helping child survivors, and their families, recover and heal from the oftentimes devastating impacts of sexual abuse.

On behalf of the IRC, I would like to extend a special word of appreciation to the U.S. Department of State's Bureau of Population, Refugees and Migration, the Bill & Melinda Gates Foundation and the United Nations Children's Fund (UNICEF) for making the development of these guidelines possible. This generous support has allowed the IRC to develop a child-centered model of care and accompanying guidelines to support humanitarian field staff caring for child survivors of sexual abuse. I would like to also recognize UNICEF for their role as technical partners in the CCS Initiative.

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We hope these guidelines will benefit child survivors in humanitarian settings throughout the world, as well as the individuals who help to provide for their care and treatment.

Thank you,



Heidi Lehmann

DIRECTOR, WOMEN'S PROTECTION AND EMPOWERMENT TECHNICAL UNIT
INTERNATIONAL RESCUE COMMITTEE

TABLE OF CONTENTS

INTRODUCTION	4
Overview of the Caring for Child Survivors (CCS) Resources	
CCS Theory of Change	
Using the CCS Guidelines	
Glossary of Terms	
CHAPTER ONE: CORE CHILD SEXUAL ABUSE KNOWLEDGE COMPETENCIES	21
Core Child Sexual Abuse Knowledge Competency Areas	
Guidelines for Assessing and Monitoring Core Knowledge Competencies	
CHAPTER TWO: CORE CHILD-FRIENDLY ATTITUDE COMPETENCIES	51
Core Child-Friendly Attitude Competency Areas	
Guidelines for Assessing and Monitoring Core Attitude Competencies	
CHAPTER THREE: CORE SKILLS: ENGAGING AND COMMUNICATING WITH CHILD SURVIVORS	59
Developing a Helping Relationship through Safe and Healing Communication Strategies	
Best Practices for Communicating with Child Survivors	
Guidelines for Communicating with Children about their Experience of Sexual Abuse	
Addressing Common Communication Challenges	
Guidelines for Assessing and Monitoring Core Communication Skill Competencies	
CHAPTER FOUR: GUIDING PRINCIPLES AND KEY ISSUES	87
Guiding Principles for Working with Child Survivors of Sexual Abuse	
Caring for Child Survivors Key Issues	
Issue 1: Mandatory Reporting Requirements	
Issue 2: Confidentiality Protocols in Child Cases	
Issue 3: Ensuring the Best Interest of the Child: Balancing Roles in Decision-Making	
CHAPTER FIVE: CASE MANAGEMENT FOR CHILD SURVIVORS	105
Introduction to Case Management	
Steps of Case Management for Child Survivors of Sexual Abuse	
Step 1: Introduction and Engagement	
Step 2: Intake and Assessment	
Step 3: Develop Case Goals and Action Plan	
Step 4: Implement the Case Action Plan	
Step 5: Case Follow-up and Monitoring Progress	
Step 6: Case Closure and Evaluating Service	
Step 7: Service Evaluation	

CHAPTER SIX: PSYCHOSOCIAL INTERVENTIONS FOR CHILD SURVIVORS	187
Integrating Psychosocial Interventions into a Child and Family's Care and Treatment	
Assessing the Psychosocial Needs of Child Survivors	
Guidelines for Implementing Core Psychosocial Interventions	
CHAPTER SEVEN: BEST PRACTICES FOR CASE COORDINATION BETWEEN SERVICE PROVIDERS	231
Best Practice in Coordinating Child Case Response	
FINAL NOTE TO THE READER	239

CCS TOOLS

Please note: related staff monitoring tools and/or sample case management forms are included at the end of each chapter. A list of the CCS tools and relevant page numbers are included below.

CCS KNOWLEDGE ASSESSMENT TOOL (CCS-KA)	45
CCS ATTITUDE SCALE	57
CCS COMMUNICATION ASSESSMENT TOOL (CCS-CA)	83
CHILD NEEDS ASSESSMENT AND CASE ACTION PLAN	170
CHILD CASE FOLLOW-UP FORM	172
CHILD CASE CLOSURE FORM	174
CHILD CLIENT SATISFACTION QUESTIONNAIRE	175
CCS CASE MANAGEMENT SKILLS ASSESSMENT TOOL (CCS-CMA)	180
CCS CASE MANAGEMENT CHECKLIST	183
CHILD AND FAMILY PSYCHOSOCIAL NEEDS ASSESSMENT TOOL	225

Tools and other reference documents not specific to a particular chapter are included at the end of the guidelines.

MINIMUM STANDARDS FOR CASE MANAGEMENT	240
GBVIMS INTAKE AND ASSESSMENT FORM	241

INTRODUCTION

OVERVIEW OF THE CARING FOR CHILD SURVIVORS (CCS) RESOURCES

GOAL

The ultimate goal of the Caring for Child Survivors Resources is to enable and empower staff in humanitarian aid contexts to provide high quality care to children and families affected by sexual abuse.

The International Rescue Committee (IRC), in partnership with the U.S. Department of State, the United Nations Children's Fund (UNICEF) and the Bill & Melinda Gates Foundation have dedicated resources toward developing a program model of care¹ and guidelines for implementing the model of care for child survivors of sexual abuse across humanitarian settings. The purpose of developing these resources is to provide guidance on how to:

- » Build the capacity of health and psychosocial service providers on the foundational (or “core”) knowledge, attitudes and skills to work with child survivors of sexual abuse.
- » Adapt case management for child survivors.
- » Implement targeted psychosocial interventions.
- » Improve coordinated care across multiple sectors and service providers.
- » Monitor the quality of service provision.

¹ The CCS Program Model is also referred to as the CCS Theory of Change. This references the logical framework developed to help child survivors recover and heal from sexual abuse.

The Caring for Child Survivors (CCS) Resource Package is based on global research on child sexual abuse and evidence from field practice. The CCS Resource Package brings a much-needed comprehensive and practical approach to helping child survivors and their families recover and heal from the impacts of sexual abuse. The three main components are:

- » **Literature Review:** An in-depth literature review of available evidence and promising practice to improve case management, psychosocial care, and clinical care for child survivors of sexual abuse.²
- » **CCS Program Model:** The logical model or “theory of change” that outlines the service delivery components necessary to help children recover and heal from sexual abuse.
- » **CCS Guidelines:** The CCS Guidelines (this document) provide step-by-step guidance on how to implement the main aspects of the CCS Program Model. The CCS Guidelines is the “how-to” guide for instructing health and psychosocial field staff responding to children who have experienced sexual abuse. The CCS Guidelines include multiple tools for monitoring and evaluating the program model, such as: knowledge and skills competency assessments and case management monitoring and evaluation tools.

CCS THEORY OF CHANGE AND INTENDED OUTCOMES

The technical guidance outlined in this document comes from the CCS program model or “theory of change” outlined on the next page. The CCS theory of change posits that children can be supported in their recovery and healing from sexual abuse with child-specific, compassionate and appropriate care and treatment. The theory of change outlines the key elements of care and treatment and the knowledge, skills and attitudes required for health and psychosocial service providers to be able to provide such care.

² The CCS literature review is titled: Advancing the Field, Caring for Child Survivors of Sexual Abuse in Humanitarian Settings. A Review of Promising Practices to Improve Case Management, Psychosocial & Mental Health Interventions, and Clinical Care for Child Survivors of Sexual Abuse. May 2010

CCS THEORY OF CHANGE

KEY ELEMENTS OF CARE FOR CHILD SURVIVORS OF SEXUAL ABUSE

CHILD SURVIVORS HAVE ACCESS TO CHILD CENTERED CASE MANAGEMENT SERVICES

Caseworkers have the knowledge, skills, attitudes and tools to provide child-centered case management.

- » Understand and able to apply child sexual abuse concepts in case management.
- » Possess child-friendly attitudes that contribute to recovery and healing.
- » Able to communicate with child survivors according to age and developmental stage.
- » Able to adapt case management services for child sexual abuse cases.
- » Understand and able to apply CCS Guiding Principles in case management.
- » Able to use child-friendly tools to aid effective case management services
- » Able to appropriately engage caregivers in the child's care and treatment.
- » Able to monitor activities using established tools.

CHILD SURVIVORS HAVE ACCESS TO CHILD SPECIALIZED CLINICAL CARE & TREATMENT SERVICES

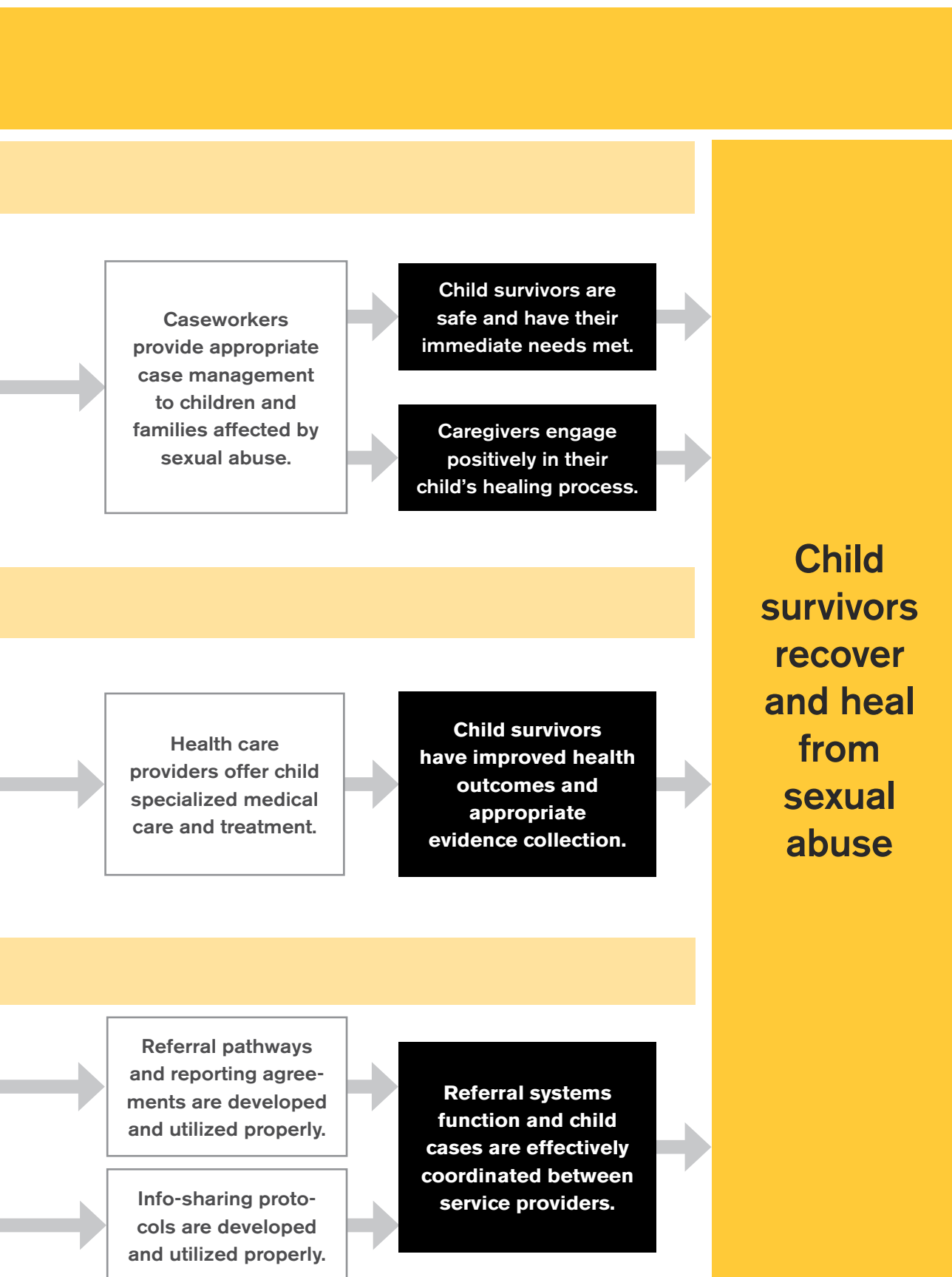
Health Providers have the knowledge, skills, attitudes and tools to provide specialized medico-legal care for child survivors.

- » Understand child growth and development and child sexual abuse concepts.
- » Able to communicate effectively with child survivors.
- » Understand and able to apply CCS Guiding Principles in case management.
- » Able to adapt the medical exam and treatment for child survivors.
- » Able to ensure safe and appropriate referrals and follow-up systems are in place.
- » Able to monitor activities using established tools.

HEALTH & PSYCHOSOCIAL SERVICE PROVIDERS COORDINATE CARE ACCORDING TO BEST PRACTICE

Service Providers have the knowledge, skills, attitudes and tools to use referral pathways, reporting agreements and information sharing protocols.

- » Able to understand essential components to case coordination.
- » Able to demonstrate best practice for coordinating child sexual abuse cases.
- » Service provider agreements that outline referral and information sharing protocols exist.
- » Agreements and guidelines for interacting with legal and reporting systems exist.
- » Able to monitor activities using established tools.



NOTE ON LANGUAGE

The term **service provider** is used when referring to both health and psychosocial professionals. The term **caseworker** is used when referencing an individual tasked with the responsibility to provide case management services to child survivors.

The term **caregiver** is used to refer to the person and/or persons exercised day-to-day care for a child. This includes biological parents and/or other guardians responsible for the child's care and well-being.



Photo: Photographer Unknown/the IRC

USING THE CCS GUIDELINES

WHO CAN BENEFIT FROM THE CCS GUIDELINES?

The primary target audience for the CCS Guidelines (referred to as “the guidelines” from now on) is staff who provide psychosocial, case management and/or health services for survivors of gender-based violence (GBV) and/or children in humanitarian settings. United Nations and NGO protection and gender-related staff can also benefit from the guidelines and other components of the CCS Resource Package.

WHAT ARE THE GOALS AND AIMS OF THE CCS GUIDELINES?

The goal is to provide staff with a user-friendly tool that offers best practice guidance on caring for child survivors in humanitarian settings. The guidelines aim to improve care for child survivors (and their non-offending family members), in order to help them recover and heal from abusive experiences. The guidelines and accompanying tools will equip field staff with the necessary knowledge, skills and attitudes to provide high-quality care to children and families affected by sexual abuse.

OVERVIEW OF THE CHAPTERS

The guidelines walk readers through a step-by-step process for building capacity among health and psychosocial service providers by focusing on the core knowledge, attitudes and skills required for providing care to child survivors. Chapters 1–3 of the guidelines outline core competencies that apply to both health and psychosocial service providers. Chapters 4–6 are designed for GBV and/or child protection program staff who deliver case management services to GBV survivors, including children. Chapter 7 provides concise guidance for coordinating care across health, child protection, GBV and other providers.

- » **Chapter 1:** This chapter outlines the **core child sexual abuse knowledge areas** that service providers must have prior to working with children and families. The chapter walks through a set of core knowledge areas and introduces a supervision tool that can be used to assess an individual staff member's knowledge competency.
- » **Chapter 2:** This chapter outlines the **core child-friendly attitude competencies** that service providers must have in order to work with children and families. The chapter walks through these core attitudes, including beliefs about child sexual abuse, and introduces a supervision tool for assessing attitude competencies.
- » **Chapter 3:** This chapter outlines **key principles of communication** with child survivors, including instructions on how to communicate with children about the experience of sexual abuse. This section also explains verbal and non-verbal techniques that can be used to help children feel safer and more comfortable with expressing themselves.
- » **Chapter 4:** This chapter introduces the reader to the **guiding principles for working with child survivors** and key issues that affect the delivery of care and treatment. It specifically addresses how to handle mandatory reporting for child abuse cases, confidentiality protocols and the roles of children and caregivers in decision-making. The discussion emphasizes the best interest of the child principle.
- » **Chapter 5:** This chapter walks the reader through the **step-by-step process of how to provide case management for child survivors** and explains how to adapt case management techniques for children of different ages. This chapter provides sample case management forms for use in responding to cases of child sexual abuse and introduces supervision tools for assessing case management competencies and evaluating applied practice.
- » **Chapter 6:** This chapter introduces additional tools and interventions for staff to implement **direct psychosocial care interventions for child survivors and family members** as part of case management services. This chapter will help psychosocial staff build targeted, person focused psychosocial interventions for child survivors into their overall response services (e.g. case management or psychosocial services).
- » **Chapter 7:** This chapter provides **a concise overview of best practices** related to child case coordination across multiple service providers.

KEY ASSUMPTIONS AND PARAMETERS TO THE GUIDELINES

The guidelines specifically address responding to cases of child sexual abuse—they are not general GBV or child protection response guidelines. It is necessary for field agencies implementing these guidelines to have established response services, or at least the capacity to develop such services and/or be working with local partners providing services to survivors of gender-based violence or children facing broader protection concerns. Agencies and staff should already be trained and able to demonstrate competency in:

- » caring for survivors of gender-based violence³ and/or providing care and support to children with broader protection concerns, and
- » basic case management and psychosocial care skills.

Health staff should have also received training in clinical care for sexual assault survivors.⁴

The following parameters to the guidelines should be noted:

- » The guidelines are designed solely for the purpose of providing care and response services for child survivors of sexual abuse and their families. While aspects of the guidelines can be applied to other forms of gender-based violence experienced by children (such as other forms of child abuse and exploitation) or to broader case management support, the specific focus here is child sexual abuse.
- » The guidelines provide step-by-step direction on how to provide case management and psychosocial interventions for child survivors and their families. The guidelines do not address community-based interventions (such as integrating children into child-friendly spaces or community-based interventions to combat social stigma and discrimination); however, they do offer suggestions for making appropriate referrals to agencies that might support these kinds of community-based interventions or provide these services.
- » The guidelines are meant for children under the age of 18. However, approaches to communication and care outlined here will need to be adapted to a child's age and developmental stage. Age and developmental stage are taken into consideration throughout the guidelines.

³ These guidelines should be used in conjunction with the Caring for Survivors of Sexual Violence in Emergencies training package developed by the Inter-Agency Standing Committee (IASC) Sub-Working Group on Gender in Humanitarian Action with support from the Gender-Based Violence Area of Responsibility (GBV AoR) and/or other high quality GBV response training materials. In addition, the guidelines should be used with other standard guidelines for responding to GBV in humanitarian settings, such as the IASC Guidelines for Preventing and Responding to Gender-Based Violence in Humanitarian Contexts.

⁴ The International Rescue Committee (IRC) and the University of California, Los Angeles (UCLA) Center for International Medicine. (2008). Clinical care for sexual assault survivors: A multimedia training tool, Facilitator's guide. <http://clinicalcare.rhrc.org/docs/facguide.pdf>.

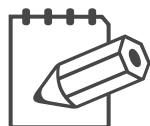
- » The guidelines are designed for service providers working in humanitarian settings where services for survivors of GBV and/or children are in place, and agencies meet the minimum requirements for providing case management services.⁵ When referring to case management services and/or caseworkers, the guidelines assume that the individuals are working within agencies that meet the standards outlined in this document.
- » The guidelines do not address treatment of perpetrators or prevention of sexual abuse, despite evidence showing that systemic interventions, raising awareness and prevention programs create safer communities.
- » The guidelines are not a training manual. Therefore, program coordinators and managers will need to adapt the content to training curricula appropriate to specific cultures and contexts.

GUIDE TO UNDERSTANDING ICONS

Read through the entire guidelines before deciding how best to apply the tools and guidelines in your program. Readers will notice the following icons throughout the manual to help better navigate this document.



SAMPLE SCRIPT



TOOL



HELPFUL TIP

⁵ Minimum standards for agencies providing case management can be found on page 240.

GLOSSARY OF TERMS

Common terms and definitions used in this document are defined below. These terms and definitions are not legal definitions and are not intended as such.⁶

NOTE

The IRC uses the term “children” to describe individuals under the age of 18. These definitions fall in line with international conventions as summarized in the definition of “child” below. The term “adolescent” is not intended to replace the use of “children,” but instead provide an additional term to describe specific ages, maturation and life stages of individuals aged 10–19. The author of this document understands that the terms “children” and “adolescent” take on different meanings in different contexts.

ADOLESCENCE: defined as the period between ages 10 and 19 years old. It is a continuum of development in a person's physical, cognitive, behavioral and psychosocial spheres.

ADOLESCENT: Any person between the ages of 10–19 years old.

⁶ In an effort to ensure consistency, to the extent possible, some definitions have been taken directly from the IASC Guidelines on Gender-Based Violence Interventions in Humanitarian Settings. Other definitions are sourced accordingly.

ADULT: Any person 18 years and older.

ASSESSMENT: The beginning stage of case management or psychosocial services in which information is gathered and evaluated for the purpose of making an appropriate decision about a course of action. Assessment prevents assumptions, creates grounds for developing an appropriate plan of action, and helps identify survivor strengths.

ATTITUDE: Opinion, feeling or position about people, events, and/or things that is formed as a result of one's beliefs. Attitudes influence behavior.

BELIEF: An idea that is accepted as true. It may or may not be supported by facts. Beliefs may stem from or be influenced by religion, education, culture and personal experience.

CAREGIVER: This term describes the person who is exercising day-to-day care for a child or children. He or she is a parent, relative, family friend or other guardian; it does not necessarily imply legal responsibility. This may apply to foster parents, including those who “adopt” a child spontaneously as well as those who do so formally.

CASE ACTION PLAN: The case document that outlines the main needs of the client and goals and strategies for meeting their needs and improving their current condition.

CASE CONFERENCE/MEETING:

Case conferences are small meetings with appropriate service providers (e.g. already involved in the child's care) scheduled when the child's needs are not being met in a timely or appropriate way. The purpose of the case conference is to gather the appropriate service providers (and concerned support people in the child's life as appropriate) to identify or clarify ongoing issues regarding the child clients status. Case conferences provide an opportunity to review activities including progress and barriers towards goals; to map roles and responsibilities; to resolve conflicts or strategize solutions; and to adjust current service plans.

CASE DOCUMENTATION: Information related to the provision of case management services. Generally, this information includes dates of services; the specific service provider; a brief description of the situation and the client's responses to the subject matter; relevant action plans and follow-up appointment information. Case documentation also includes dates and reason for closing the client's case.⁷

CASE MANAGEMENT: Social work-based case management is a systematic process, in which a trained and supervised caseworker assesses the needs of the client and, when appropriate, assesses the client's

family; he or she will then arrange, sometimes provide, coordinate, monitor, evaluate, and advocate for a package of multiple services to meet the specific client's complex needs.⁸

CASE SUPERVISION: The process whereby a caseworker shares case work decisions, challenges and experience with another professional (generally a direct supervisor) who offers guidance, knowledge and support. Supervision helps caseworkers improve their case management skills and allows caseworkers to share the burden of hearing and responding to clients' problems and experiences regarding violence; it also creates general awareness of the care being provided.

CASEWORKER: This term describes an individual working within a service providing agency, who has been tasked with the responsibility of providing case management services to clients. This means that caseworkers are trained appropriately on client-centered case management; they are supervised by senior program staff and adhere to a specific set of systems and guiding principles designed to promote health, hope and healing for their clients. Caseworkers are also commonly referred to as social workers, case holders, child protection workers, and GBV workers, among others.

⁷ In humanitarian settings, it is best practice to collect and store data in case files with non-identifying data only. For more information about the safe and ethical collecting, storing and usage of information, please go to www.gvbims.org.

⁸ NASW Standards for Social Work Case Management. http://www.socialworkers.org/practice/standards/sw_case_mgmt.asp#intro.

CHILD: Any person under the age of 18.⁹ Children have evolving capacities depending on their age and developmental stage. In working with children, it is critical to understand these stages, as it will determine the method of communication with individual children. It will also allow the caseworker to establish an individual child's level of understanding and their ability to make decisions about their care. As a result, the caseworker will be able to make an informed decision about which method of intervention is most appropriate for each individual child.

The following definitions clarify the term “child” with regard to age/developmental stages for guiding interventions and treatment:

- » Children = 0–18, as per the CRC
- » Young children = 0–9
- » Early adolescents = 10–14
- » Later adolescents = 15–19

CHILD AND YOUTH DEVELOPMENT:

Refers to the psychological, social, emotional, cognitive and physical changes that human beings undergo from birth to adulthood. The changes that take place—such as learning to clap, walk or talk, becoming empathic, and being able to think abstractly, to name just a few—are influenced by genetic as well as environmental factors. Many scholars have identified different “stages” of child and youth development which refer to the periods of time or age ranges during which particular changes are expected to take place. The ages associated with particular changes will

vary across individuals, and as such, stages of development are best understood on a continuum rather than a fixed timeline. Similarly, the changes occurring in children and youth tend to be processes of development rather than fixed events.¹⁰

CHILD SURVIVOR: A person under the age of 18 who has experienced any form of gender-based violence.

CHILD SURVIVOR OF SEXUAL ABUSE: A person under the age of 18 who has experienced an act of sexual abuse.

CHILD SEXUAL ABUSE: There is no set definition of child sexual abuse. The World Health Organization defines child sexual abuse as “the involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared and cannot give consent, or that violates the laws or social taboos of society. Child sexual abuse is evidenced by this activity between a child and an adult or another child who by age or development is in a relationship of responsibility, trust or power, the activity being intended to gratify or satisfy the needs of the other person. This may include but is not limited to:

- » the inducement or coercion of a child to engage in any unlawful sexual activity,
- » the exploitative use of a child in prostitution or other unlawful sexual practices,

⁹ According to the United Nations Convention of the Rights of the Child.

¹⁰ International Rescue Committee's Child and Youth Protection and Development Sector Framework. A guide to sound project design and consistent messaging. January 2012.

- » the exploitative use of children in pornographic performances and materials.”¹¹

We use the following definition in an effort to more succinctly define child sexual abuse for teaching and training purposes:

“Child sexual abuse is defined as any form of sexual activity with a child by an adult or by another child who has power over the child. By this definition, it is possible for a child to be sexually abused by another child. Child sexual abuse often involves body contact. This could include sexual kissing, touching, and oral, anal or vaginal sex. Not all sexual abuse involves body contact, however. Forcing a child to witness rape and/or other acts of sexual violence, forcing children to watch pornography or show their private parts, showing a child private parts (“flashing”), verbally pressuring a child for sex, and exploiting children as prostitutes or for pornography are also acts of sexual abuse.”¹²

CONFIDENTIALITY: Confidentiality is an ethical principle that is associated with medical and social service professions. Maintaining confidentiality requires that service providers protect information gathered about clients and agree only to share information about a client’s case with their explicit permission. All written information is maintained

in a confidential place in locked files and only non-identifying information is written down on case files. Maintaining confidentiality means service providers never discuss case details with family or friends, or with colleagues whose knowledge of the abuse is deemed unnecessary. There are limits to confidentiality while working with children.

COMPETENCY: The ability to do something well as measured against a defined standard.

CORE COMPETENCY: The ability to perform a specific set of skills that will best meet the needs of the client. In these guidelines, core competencies are related to a unique skill set for working with child survivors.

DISCLOSURE: The process of revealing information. Disclosure in the context of sexual abuse refers specifically to how a non-offending person (for example, a caregiver, teacher or helper) learns about a child’s experience with sexual abuse. Children disclose sexual abuse differently and disclosure is often a process rather than a single or specific event. Disclosure about sexual abuse can be directly or indirectly communicated, voluntarily or involuntarily.

- » **Direct:** child survivors or child survivors’ family members or friends directly share information about the abuse with a service provider [because the child has told them directly].

¹¹ World Health Organization, Social Change and Mental Health, Violence and Injury Prevention, Report of the Consultation on Child Abuse Prevention, pp. 13-17, Geneva, 29-31 March 1999.

¹² This definition is a compilation from various definitions of child sexual abuse.

- » **Indirect:** A witness to sexual abuse shares information with a third party or a child contracts a sexually transmitted disease or becomes pregnant, and this event propels the abuse to be disclosed.
- » **Voluntary:** A child readily shares information or requests that another person share information about sexual abuse.
- » **Involuntary:** Person shares information about sexual abuse against the child's wishes, or the child is forced into disclosing sexual abuse.

EMPATHY: Attempting to see things from the child survivor's point of view and sharing that understanding with the child survivor. Empathy can be communicated through verbal and non-verbal communication.

KNOWLEDGE: The service provider must be sure his or her information is consistent and accurate.

GENDER-BASED VIOLENCE: An umbrella term for any harmful act that is perpetrated against a person's will; it is based on socially ascribed (gender) differences between males and females. Gender-based violence encompasses a wide range of human rights violations, including sexual abuse of children, rape, domestic violence, sexual assault and harassment, trafficking of women and girls and several harmful traditional practices, including forced, early marriage.¹³

¹³ Inter-Agency Standing Committee (IASC) (2005) Guidelines for GBV interventions in humanitarian settings: Focusing on prevention of and response to sexual violence in emergencies. Accessed at: http://www.humanitarianinfo.org/iasc/content/subsidi/tf_gender/gbv.asp.

HUMANITARIAN WORKER: An employee or volunteer, whether internationally or nationally recruited, or formally or informally retained from the beneficiary community, engaged by a humanitarian agency to conduct the activities of that agency.

INCEST/INTRA-FAMILIAL SEXUAL ABUSE: Sexual abuse that occurs within the family. In this form of abuse, a family member involves a child in (or exposes a child to) sexual behavior or activity. The "family member" may not be a blood relative, but someone considered "part of the family," such as a godparent or very close friend.

INFORMED ASSENT: Informed assent is the expressed willingness to participate in services. For younger children who are by definition too young to give informed consent, but old enough to understand and agree to participate in services, the child's "informed assent" is sought. Informed assent is the expressed willingness of the child to participate in services.

INFORMED CONSENT: Informed consent is the voluntary agreement of an individual who has the legal capacity to give consent. To provide informed consent, the individual must have the capacity and maturity to know about and understand the services being offered and be legally able to give their consent. Parents are typically responsible for giving consent for their child to receive services until the child reaches 18 years of age. In some settings, older adolescents are also legally able to provide consent in lieu of, or in addition to, their parents. To ensure consent is

“informed”, service providers must provide the following information to the client:

- » Giving the client all the possible information and options available to him/her so he/she can make choices.
- » Informing the client that he/she may need to share his/her information with others who can provide additional services.
- » Explaining to a client what is going to happen to him/her.
- » Explaining the benefits and risks of the service to the client.
- » Explaining to the client that he/she has the right to decline or refuse any part of services.
- » Explaining limits to confidentiality.

MANDATORY REPORTING: This refers to state laws and policies which mandate certain agencies and/or persons in helping professions (teachers, social workers, health staff, etc.) to report actual or suspected child abuse (e.g., physical, sexual, neglect, emotional and psychological abuse, unlawful sexual intercourse).

PARENT: The child’s biological mother or father. Note that in some societies it is common for girls and boys to spend time with other members of their extended family and sometimes with unrelated families. Throughout this publication, the term “parent” generally refers to the biological parent. In some cases, it may refer to the person or persons who assume the child’s care on a permanent basis, such as for example, foster

or adoptive parents, or extended family members providing long-term care.

PERPETRATOR: A person who directly inflicts or supports violence or other abuse inflicted on another against his/her will.

POST-TRAUMATIC STRESS

DISORDER (PTSD): A neuropsychiatric disorder that may develop following a traumatic event. Symptoms of PTSD include changes in emotional, behavioral, or physiological function. It is characterized by three key sets of such symptoms:

- » Re-experience and re-enactment
- » Avoidance
- » Physiological hyper-reactivity that affects an individual’s ability to function.¹⁴

PROTOCOL: An interagency agreement that delineates joint roles and responsibilities by establishing criteria and procedures for working together on specific areas of work (e.g., cases of child sexual abuse).

PROTECTIVE FACTORS: External factors that are supportive for the child, reduce risk and encourage the development of acquired resilience or learned coping mechanisms. These factors include mechanisms at the family and community levels, conditions such as socioeconomic status, and proximity to services and other people.

¹⁴ American Psychological Association. (1994). Diagnostic and statistical manual of mental disorders (4th ed.). Washington, D.C.: Author.

RESILIENCE: The ability of individuals, families and communities to maintain or recover one's well-being despite experiencing adversity. This results from both individual characteristics and coping mechanisms (innate and acquired) and the protective factors in a child or youth's ecology or environment.¹⁵

RESPONSIBILITY: The service provider's responsibility to facilitate their work in ways that respect child survivors' values, personal resources and capacity for self-determination.

SERVICE PROVIDER: Health and psychosocial service providers charged with providing direct services to children and/or survivors of gender-based violence. These professionals include caseworkers, social workers, health workers, child protection workers, etc. **Note:** this term does not refer to police and/or law enforcement officers, although much of the guidance in the knowledge, attitude and communication sections can apply to police and law enforcement professionals as well.

SEXUAL EXPLOITATION: Any actual or attempted abuse of a position of vulnerability, differential power or trust for sexual purposes. This includes profiting monetarily, socially or politically from the sexual exploitation of another (see also sexual abuse).¹⁶

SURVIVOR/VICTIM: A person who has experienced gender-based violence. The terms "victim" and "survivor" can be used interchangeably, although "victim" is generally preferred in the legal and medical sectors, and "survivor" in the psychological and social support sectors. Throughout this guideline, we use "child survivor."

TRAUMA: Traumatic experiences usually accompany a serious threat or harm to an individual's life or physical well-being and/or a serious threat or harm to the life or physical well-being of the individual's child, spouse, relative or close friend. When people experience a disturbance to their basic psychological needs (safety, trust, independence, power, intimacy and esteem), they experience psychological trauma. "Traumatic events overwhelm the ordinary systems of care that give people a sense of control, connection and meaning."¹⁷

¹⁵ International Rescue Committee's Child and Youth Protection and Development Sector Framework. A guide to sound project design and consistent messaging. January 2012.

¹⁶ Sexual exploitation is from the Secretary General's Bulletin, Special measures for protection from sexual exploitation and abuse. October 2003.

¹⁷ Herman, J. Trauma and Recovery, p. 33.



Chapter One

CORE CHILD SEXUAL ABUSE KNOWLEDGE COMPETENCIES

This chapter applies to health and psychosocial service providers.

CONTENTS OF THIS CHAPTER INCLUDE

- » Core Child Sexual Abuse Knowledge Competency Areas

TOOLS IN THIS CHAPTER INCLUDE

- » Caring for Child Survivors Knowledge Assessment (CCS-KA) Tool

CHAPTER OVERVIEW

This chapter applies to health and psychosocial service providers working with children and families affected by sexual abuse. This chapter outlines the core child sexual abuse knowledge areas required for service providers to apply and complement other professional knowledge and skill competencies.¹⁸ Accurate and full knowledge about child sexual abuse is central to delivering appropriate care and treatment to children and families. Service providers have the responsibility to share accurate knowledge about sexual abuse to facilitate recovery and healing. Without accurate knowledge, service providers may perpetuate harmful beliefs that can cause further emotional distress and prevent healing.

In addition to outlining the child sexual abuse knowledge areas, this section introduces a tool for supervisors to assess the knowledge and competencies of individual staff members.

¹⁸ For example, doctors and nurses must demonstrate competent clinical care for sexual assault survivors and psychosocial workers must show competency in case management, in addition to this specialized technical knowledge about sexual abuse.

Note: These knowledge areas are drawn from global facts and information related to the scope of the problem of child sexual abuse, children's reactions to abuse and dynamics related to disclosure of abuse, among other knowledge areas. Therefore, adapting these facts and information to be more locally specific is necessary, as information related to the knowledge areas will vary across local contexts and populations.

CORE CHILD SEXUAL ABUSE KNOWLEDGE COMPETENCY AREAS

Health and psychosocial staff have the ability to demonstrate proficient knowledge in core sexual abuse knowledge areas:

- AREA 1:** Definition of child sexual abuse
- AREA 2:** Scope of the problem
- AREA 3:** Children and sexual abuse disclosure
- AREA 4:** Perpetrators of sexual abuse
- AREA 5:** Sexual abuse and boys
- AREA 6:** Sexual abuse impact across age and developmental stages
- AREA 7:** Impact of sexual abuse on caregivers
- AREA 8:** Needs of children after sexual abuse
- AREA 9:** Children and resilience
- AREA 10:** Local child protection mechanisms and norms
- Additional Knowledge Areas (developed locally)

Health and psychosocial staff are committed to:

- » Having an accurate understanding of child sexual abuse and sharing accurate information with children and caregivers.
- » Helping children understand and manage the impacts of abuse through child-friendly education and information sharing.
- » Helping families heal by educating about child sexual abuse and supporting the affected child.
- » Educating service providers who share misinformation about sexual abuse with children, families and/or community members.

KNOWLEDGE AREA 1: DEFINITION OF CHILD SEXUAL ABUSE¹⁹

Sexual abuse is an abuse of power over a child and a violation of a child's right to life and normal development through healthy and trusting relationships. Globally, there is no standard definition of child sexual abuse. The World Health Organization (WHO) defines child sexual abuse as:

“the involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared and cannot give consent, or that violates the laws or social taboos of society. Child sexual abuse is evidenced by this activity between a child and an adult or another child who by age or development is in a relationship of responsibility, trust or power, the activity being intended to gratify or satisfy the needs of the other person.”²⁰

In line with the WHO definition, child sexual abuse is defined in these guidelines as any form of sexual activity with a child by an adult or by another child who has power over the child. Child sexual abuse often involves body contact. This could include sexual kissing, touching, and oral, anal or vaginal sex. Not all sexual abuse involves body contact, however. Forcing a child to witness rape and/or other acts of sexual violence, forcing children to watch pornography or show their private parts, showing a child private parts (“flashing”), verbally pressuring a child for sex, and exploiting children as prostitutes or for pornography are also acts of sexual abuse. Specific acts of sexual abuse that include both contact and non-contact behaviors are outlined below.

Abusive physical contact or touching includes:

- » touching a child's genitals or private parts for sexual purposes,
- » making a child touch someone else's genitals or play sexual games,
- » and putting objects or body parts (such as fingers, tongue or penis) inside the vagina, in the mouth or in the anus of a child for sexual purposes.

¹⁹ The information explained in this section combines data from multiple resources. Three main resources include the National Child Traumatic Stress Network (www.nctsn.com); Stop it Now: Together We Can Prevent Child Sexual Abuse (<http://www.stopitnow.com/>); and Levine, P. (2007). Trauma through a child's eye. California: North Atlantic Books. In addition, the WHO, UNICEF and other key sources of information are cited.

²⁰ World Health Organization, Social Change and Mental Health, Violence and Injury Prevention, Report of the Consultation on Child Abuse Prevention, pp. 13-17, Geneva, 29-31 March 1999.

Many people are unaware that sexual abuse does not require penetration, force, pain or even touching. If an adult engages in any sexual behavior (e.g., inappropriate sexual language directed at a child, looking at a child's private parts and/or showing private parts to a child) to satisfy the adult's sexual desires or interest, such behavior is considered sexual abuse. Acts of sexual abuse that do not involve contact or touching include:

- » showing pictures of naked men and/or women to a child,
- » deliberately exposing an adult's genitals to a child for the adult's sexual pleasure or interest,
- » photographing a child in sexual poses,
- » encouraging a child to watch or hear sexual acts,
- » watching a child undress or use the bathroom for the adult's sexual pleasure or interest,
- » and forcing a child to witness rape and/or other acts of sexual violence.

It is important to recognize that some forms of sexual abuse may be socially promoted, for example, early marriage of girls and young women. In many humanitarian settings, early and forced marriage of young girls is the vehicle for marital rape.

Sexual abuse of children is most often perpetrated by someone close to the child, resulting in the betrayal of the child's trust. Therefore, use of physical force is often unnecessary to engage a child in sexual activity because children trust and often depend on adults they are close to. Children are taught not to question authority and may believe that adult behaviors are always correct, or the adult has unchallengeable authority. Perpetrators of child sexual abuse take advantage of these vulnerabilities in children.

KNOWLEDGE AREA 2: SCOPE OF THE PROBLEM

Acknowledging that sexual abuse happens can be difficult for members of any community. Yet, the statistics show that globally, sexual violence toward children is alarmingly common. While sexual abuse statistics vary between countries and reports, the data is disturbing:

- » Girls are up to three times more likely than boys to experience sexual violence. The majority of perpetrators of sexual violence are men.²¹

²¹ Heise, Lori; Ellsberg, Mary; Gottemoeller, Megan. 1999. "Ending Violence Against Women." Population Reports, Series L. No.

- » The World Health Organization (WHO) estimates that 150 million girls and 73 million boys under 18 experienced forced sexual intercourse or other forms of sexual violence in 2002.²²
- » The occurrence of sexual violence in the home is increasingly acknowledged. An overview of studies in 21 countries found that 7–36 % of women and 3–29% of men reported sexual victimization during childhood. Most of the abuse occurred within the family circle.²³
- » Similarly, a multi-country study by the WHO, including both developed and developing countries, showed that between 1% and 21% of the women interviewed had been sexually abused before the age of 15, in most cases by male family members other than the father or stepfather.²⁴

Data from IRC-supported gender-based violence (GBV) programs collected in conflict-affected settings highlight the frequency of sexual violence toward children. For instance, in the Central African Republic, nearly half of GBV survivors receiving support from the IRC are girls under the age of 18. In Sierra Leone, 73% of female survivors aided by the IRC are under the age of 18, with 23% under the age of 11. Almost all cases were sexual violence, specifically rape (97% for 0–11 year olds and 96% for 12–18 year olds).²⁵

It is widely acknowledged that child sexual abuse occurs more often than the reported numbers show. Children comprise a resilient group of the population but are vulnerable given their age, size, dependency on adults and their limited participation in decision-making processes.²⁶ Children especially vulnerable to abuse include those who:

- » have physical or mental/developmental disabilities,
- » are internally displaced or refugees,
- » are unaccompanied and/or separated from their families and caregivers,
- » or live on the streets, in a residential care center or in abusive households.

²² Krug E.G. et al., eds. World Report on Violence and Health. Geneva, World Health Organization, 2002. (http://www.who.int/violence_injury_prevention/violence/world_report/en/Full%20WRVH%20summary.pdf)

²³ Child Abuse & Neglect, 2005.

²⁴ Violence Against Women: WHO Consultation, Geneva, Feb. 5–7 1996 (document FRH/WHO/96.27, available at http://whqlibdoc.who.int/hq/1996/FRH_WHO_96.27.pdf, accessed March 18, 2005).

²⁵ This data is collected from the IRC Gender-Based Information Management System, an information collection and analysis tool that compiles and analyzes information on reported GBV. The data shown here does not represent the total incidence or prevalence of GBV in any one location or group of locations.

²⁶ Inter-Agency Standing Committee (IASC). Guidelines for GBV Interventions in Humanitarian Settings: Focusing on Prevention of and Response to Sexual Violence in Emergencies. (available at http://www.humanitarianinfo.org/iasc/content/subsidi/tf_gender/gbv.asp).

KNOWLEDGE AREA 3: CHILDREN AND SEXUAL ABUSE DISCLOSURE

“Disclosure”²⁷ refers to the discovery of child sexual abuse. A child’s capacity to disclose is impacted by several factors, including the child’s age, sense of safety, available resources and other factors relevant to a particular context. Often, disclosure of sexual abuse is a process; in other words, children may first “test the waters” to see how adults react to hints about their sexual abuse or give their full disclosure. Adults who react with anger, blame or other negative responses may cause a child to stop talking and/or later deny the abuse disclosed by the child. Service providers are responsible for responding to child sexual abuse disclosure with compassion, care and calm.²⁸

CHILD SEXUAL ABUSE CAN BE DIRECTLY OR INDIRECTLY DISCLOSED

- » Direct disclosure occurs when the child survivor or the child survivor’s family members/ friends directly informs the service provider about the abuse.
- » Indirect disclosure occurs when someone witnesses child sexual abuse, or when the child contracts a sexually transmitted disease or becomes pregnant and the disclosure is brought to the surface by a third party or consequence of the abuse (e.g. pregnancy).

Direct and indirect disclosures can occur with or without the child’s consent. For example, children may tell their caregivers that they have been sexually abused, and the caregivers may then disclose the abuse to service providers without the willingness of the child. This is considered “involuntary disclosure.” However, children can also willingly share information about sexual abuse to trusted adults or service providers themselves. This is called “voluntary disclosure.”

Voluntary and involuntary disclosure becomes a necessary consideration when service providers begin care and treatment for an individual child. How the abuse was discovered and disclosed, how the child reacted to its revelation and the number of people who talked with the child may affect a child’s willingness to participate in the disclosure process. Some children may be ready to talk, share and receive help while some children may be afraid to do so—every child’s experience is different.

²⁷ The information explained in this section draws upon three key resources: National Child Traumatic Stress Network (www.nctsn.com); Stop it Now: Together We Can Prevent Child Sexual Abuse (<http://www.stopitnow.com/>); and Levine, P. (2007). Trauma through a child’s eye. California: North Atlantic Books.

²⁸ How to handle disclosures of sexual abuse is discussed in more detail in Chapters 3, 5 and 6.

COMMON REASONS WHY CHILDREN DO NOT DISCLOSE SEXUAL ABUSE

FEAR OF CONSEQUENCES: Many children are afraid to tell an adult about abuse because they feel physically threatened, or because they believe they will be taken away from their families or blamed for shaming the family or involving outside authorities. The fear of the consequences may be greater than fear of the abuse itself.

FEAR OF DISMISSAL: Children are often afraid that adults will not believe them. They are afraid that their parents, community leaders, clan members, religious leaders and others will dismiss their claims and refuse to help. The perpetrator may compound this fear by convincing the child that no one will believe them, or that they will get into trouble if they speak out, etc.

MANIPULATION: The perpetrator may trick or bribe the child (for example, give the child a gift in exchange for non-disclosure). The perpetrator will often make the child feel embarrassed or guilty about the abuse. Sometimes the perpetrator will blame the child, saying he or she invited the abuse.

SELF-BLAME: Children may believe the sexual abuse is their fault or they may think the abuse is deserved (for example, the child may think it was his/her fault for inviting the perpetrator to his/her place or for being in the wrong place at the wrong time). A child may feel that they allowed the abuse and should have stopped it. **In no case is a child ever responsible for the sexual abuse they experience.**

PROTECTION: The child may want to protect the perpetrator and/or family in some way, especially if the perpetrator is close to the child and his/her family.

AGE: Children who are very young may be unaware they have experienced sexual abuse. They may think that the abuse is normal: particularly if the abuser is someone the child knows and trusts. Younger children may also have linguistic or developmental limitations that prevent disclosure.

PHYSICAL OR MENTAL DISABILITY: Children may be unable to disclose the abuse if they are unable to speak to or otherwise reach out to a service provider.

All disclosures of all sexual abuse must be heard with respect and believed. Caregivers, service providers and adults have the responsibility to hold the perpetrator responsible for the abuse and not the child.

**HELPFUL TIP ON HANDLING DISCLOSURE**

A key skill for service providers is their ability to handle the disclosure of child sexual abuse. Service providers must be aware of the impact their reactions can have on a child's psychological health. Negative, angry, accusatory reactions can further traumatize and harm a child who has disclosed sexual abuse, whereas a calm, affirming and supportive reaction can foster a child's feeling of safety and acceptance—both of which help the process of recovery and healing.

Chapter two outlines core values and beliefs that support the service provider's ability to be calm and affirming during disclosure and throughout a child's care and treatment. Chapters three and five provide guidance for the service provider on how to handle disclosures of sexual abuse and the steps to take following disclosure to assist a child survivor with their health, psychosocial, safety, and legal justice needs.

**KNOWLEDGE AREA 4:
PERPETRATORS OF SEXUAL ABUSE**

In different parts of the world perpetrators of sexual abuse may have different characteristics, although the majority of perpetrators of sexual abuse are men. Perpetrators of sexual abuse can be family members (fathers, grandparents, siblings, uncles, aunts, cousins, etc.). They can also be neighbors, religious leaders, teachers, health workers, or anyone else with close contact to children. Because of this, children can be sexually abused over a longer period of time and the abuse can happen more than once. Children can also be sexually abused by someone they do not know, although statistics confirm this is not as common.

CAN A CHILD ABUSE ANOTHER CHILD?

YES. Some children who sexually abuse other children fully understand the harmful impact of their actions. Some children, especially younger children, may not understand that his or her forceful sexual actions toward another child are harmful. Some children who commit sexual abuse have been abused in some way themselves.²⁹ It can be a learned behavior as a result of their personal experiences. It is important for children who are perpetrators of sexual abuse to also be offered psychosocial support and rehabilitation services. While most children who have been sexually abused never sexually harm another child, without treatment they may be more vulnerable to and confused about what is considered inappropriate behavior.

²⁹ Being sexually abused does not mean that the sexually abused child will always develop sexually abusive behaviors. However, without care and treatment, a child who has been sexually abused may be more at risk to being abused again or to be confused about which behaviors are appropriate.

WHY WOULD AN ADULT SEXUALLY ABUSE A CHILD?

There is no simple reason for why someone misuses a position of power or influence to be sexual with a child. The answers are not only complex, but as different as the people and situations involved. Characteristics of perpetrators vary across local cultures and contexts. For some men, sexually abusing a child is motivated by the desire to feel more power and control in their own lives. Some men are sexually attracted to children. There are many different reasons why adults abuse children. One feature is always present in the abuse: **abuse of power over a child for sexual purposes.**

KNOWLEDGE AREA 5: SEXUAL ABUSE AND BOYS

Many facts and information related to sexual abuse are applicable to both boys and girls; however, there are specific issues related to boy child survivors. Research studying the specific issues related to male survivors of sexual abuse in humanitarian settings is scant. Moreover, the differences between male and female victimization is largely impacted by cultural beliefs and stereotypes of femininity and masculinity, which vary across contexts. With this acknowledgment, current research³⁰ on male experiences of sexual abuse finds that beliefs impact how boys, particularly adolescents, experience and externalize sexual abuse:

- » A boy may see himself as less than male (emasculatation).
- » He may see himself as being powerless and thus flawed.
- » He may see himself as being labeled as sexually interested in males (homosexual).
- » Adolescent boys may also believe that no matter what, all sexual activity is appropriate for males.³¹

In general, males, especially adolescent males, may be much less likely to disclose and/or speak about their abuse experiences because being a victim can be seen as a countercultural experience for an adult male and/or male child/adolescent.

³⁰ Bergstrom, Sage. Butler, Tracy L., Karp, Cheryl L. (1997). Treatment Strategies for Abused Adolescents: From Victim to Survivor. Interpersonal Violence: The Practice Series, Volume 19.

³¹ Ibid.

1 CORE CHILD SEXUAL ABUSE KNOWLEDGE COMPETENCIES



Photo: Gina Bramucci/the IRC

Service providers working with male survivors must be aware of the specific facts and issues related to a boy's experience of sexual abuse. Service providers need to pay very close attention to their own beliefs and attitudes about a boy's experience of sexual abuse, as harmful beliefs may affect a child's willingness to disclose and cause further psychological harm. Some key facts for service providers include:

- » **Acknowledging that boys can be sexually abused.** An overview of studies in 21 countries found that 3–29 % of men reported sexual victimization during childhood. Most of the abuse occurred within the family circle. The statistics show that the majority are sexually abused by adult males; however, there are also cases of adult females sexually abusing boys, and/or male children/adolescents abusing boys.
- » **Understanding that sexual abuse does not cause homosexuality.** Service providers are responsible for educating child survivors, caregivers and community members about the effects of sexual abuse. Homosexuality carries an additional stigma across communities and mistaken beliefs about the effects of sexual abuse may make it more difficult for a male teen sexually abused by an adult male to disclose.
- » **Recognizing that boys do not always prefer to speak with male service providers.** In fact, the opposite may be true. Never assume that a boy or girl will feel more comfortable speaking with a service provider of his or her own gender. Rather, children should ideally be offered a choice of male or female service provider.

- » **Recognizing there can be internal (individual) and external (social) barriers to receiving care.** Social stigma, including the fear of being labeled homosexual, as well as issues related to victimization and masculinity may make it difficult for boys to seek help. Moreover, in many settings, services for sexual violence are geared toward women and girls; boys may not be aware of similar opportunities for them to seek help.
- » **Accepting that boys require care, support and treatment to recover and heal.** Male child survivors have the same needs as female child survivors—they need to feel safe, cared for, believed, encouraged and assured that seeking help and/or acknowledging sexual abuse is the right thing to do.

KNOWLEDGE AREA 6: SEXUAL ABUSE IMPACTS ACROSS AGE AND DEVELOPMENTAL STAGES

Sexual abuse occurs throughout childhood and across contexts, cultures and classes. Service providers, teachers, parents, caregivers, and others need to be aware of the common signs and symptoms of sexual abuse in their particular setting, because most boys and girls will remain silent. Any one sign or symptom does not mean that a child has been abused, but the presence of several signs may suggest that a child is at risk.³² Remember that it is important to believe reports of sexual abuse no matter what you observe about the child. Keep in mind that some of these signs can emerge during periods of stress, such as the loss of a loved one or other traumatic event, even long after the abuse has occurred.

Boys and girls react differently to sexual abuse based on several factors, including their age and developmental stage and cultural context. The majority of signs and symptoms are behavioral and emotional in nature, but physical changes can indicate abuse as well. The following are the most common physical signs of sexual abuse:

- » Pain, discoloration, sores, cuts, bleeding or discharges in genitals, anus or mouth;
- » Persistent or recurring pain during urination and/or bowel movements;
- » Wetting and soiling accidents unrelated to bathroom training;
- » Weight loss or weight gain;
- » Lack of personal care.

³² For some children, behavior and physical indications of abuse are not always apparent.

INFANTS AND TODDLERS (AGES 0–5)

It is common for young children (ages 0–5) to show regressive behaviors. This means that children seem to lose certain skills or behaviors they previously mastered (for example, bladder control), or they may revert to behaviors they had previously outgrown (thumb-sucking). Similarly, young children often become clingy to familiar adults, including caregivers and teachers to whom they feel close. They may also resist leaving places where they feel safe (their home or classroom), or be afraid to go places that may trigger memories of a frightening experience. Significant changes in eating and/or sleeping habits are common and young children may complain of physical aches and pains that have no medical basis.

YOUNGER CHILDREN (AGES 6–9)

Younger children may also exhibit regressive behaviors, such as asking adults to feed or dress them, or they may report unexplained physical symptoms just as young children do. However, older children have a better understanding of the meaning of sexual abuse and they have more advanced thoughts and beliefs about what they experience and what they perceive as negative consequences. This results in the development of emotional reactions ranging from sadness, fear, anxiety and anger, to feelings of shame and guilt. As a consequence, older children may begin to withdraw from their friends and refuse to go to school, or they may begin to behave aggressively. They may also be unable to concentrate, resulting in a decline in school performance.

ADOLESCENTS (AGES 10–19)

Adolescence is defined as the period between ages 10 and 19 years old. It is a continuum of development in a person's physical, cognitive, behavioral and psychosocial spheres. Adolescents face particular challenges that are specific to their developmental stage. Adolescence is often described as a time of transition into adulthood, which can be a very trying time because he or she is no longer viewed as a "child," but is not truly regarded as an "adult."³³

On one end of the continuum is early adolescence (ages 10–14), which is marked by puberty and important physical changes to the body. Although they may be emotionally and cognitively closer to children than adults, adolescents in this age group are just beginning to define their identities. As early adolescents begin to become aware of their sexuality, they may begin to

³³ The specific initiation practices that mark girls' and boys' transition from childhood to adulthood are different across cultures.

experiment with sex or be targeted for sex. Adolescents in this age group, especially girls, tend to be dependent on others, lack power within most of their relationships and are not given an opportunity to participate in the decisions that affect them.

At the other end of the continuum is late adolescence (ages 15–19), when puberty has ended but the body is still developing. Adolescents in this age group tend to act more like adults, but have yet to reach cognitive, behavioral or emotional maturity. Their capacity for analytical thought and reflection is enhanced but is also still developing. Peers are extremely important and influential during this time period. This is extremely important in relation to girls who have limited exposure to their peers and others outside their immediate families. Girls who have reached physical maturity have an increased chance of being targeted for sexual violence and exploitation.

In general, adolescents tend to place more importance on peer groups and “fitting in.” This can complicate their efforts to come to terms with sexual abuse, given the high level of stigma and shame that sexual abuse carries across communities. Adolescents may be reluctant to discuss their feelings or may even deny any emotional reactions to the sexual abuse, in part because of their desire to fit in and avoid the shame and stigma associated with sexual abuse. Adolescents, especially older adolescents, are more likely to show traumatic responses similar to those seen in adults, including:

- » Flashbacks
- » Nightmares
- » Emotional numbing
- » Avoidance of reminders of the trauma
- » Depression, suicidal thoughts
- » Difficulties with peer relationships
- » Delinquent and/or self-destructive behavior
(for example: changes in school performance, changes in or abandonment of friendships, and/or acts of self-harm).

Typically, adolescent survivors are struggling with many issues and therefore, developing a strong relationship can be difficult and time consuming for the service provider. Service providers working with abused adolescents will find that developing a rapport and building trust with an adolescent client is an important goal. As service providers develop a stronger rapport with adolescent clients, they may be more willing to share their feelings. Establishing a solid foundation of trust is paramount to the healing and recovery process.

1 CORE CHILD SEXUAL ABUSE KNOWLEDGE COMPETENCIES

For all boys and girls who experience sexual abuse, certain factors affect the severity of the reaction to abuse. These factors include:

- » **The perpetrator of the abuse:** Effects are generally worse when the perpetrator is a parent, step-parent or trusted adult, rather than a stranger. This will impact a child's ability to trust adults as well as impact their feelings of safety and security with adults.
- » **Whether or not violence was involved:** The level and degree of trauma and distress that the child experiences will be impacted if physical violence is involved. If serious physical violence is involved, the more serious the emotional and health consequences can be for the child.
- » **How long the abuse went on:** The longer the duration of the abuse, the more serious the emotional and health consequences can be for the child.
- » **Whether the child told anyone:** The response the child received when they disclosed is also critical. Doubting, ignoring, blaming and shaming responses can be extremely damaging—in some cases even more than the abuse itself.
- » **What happens after the abuse:** If a child receives care and help, they will suffer less, but if a child is blamed and shamed by the community or family, or does not receive help, this will impact a child's ability to heal, feel safe, and experience normal developmental patterns.

The table below represents the most common signs and symptoms according to age:

COMMON SIGNS AND SYMPTOMS OF SEXUAL ABUSE ACCORDING TO AGE	
INFANTS & TODDLERS (0–5)	<ul style="list-style-type: none"> » Crying, whimpering, screaming more than usual. » Clinging or unusually attaching themselves to caregivers. » Refusing to leave “safe” places. » Difficulty sleeping or sleeping constantly. » Losing the ability to converse, losing bladder control, and other developmental regression. » Displaying knowledge or interest in sexual acts inappropriate to their age.
YOUNGER CHILDREN (6–9)	<ul style="list-style-type: none"> » Similar reactions to children ages 0–5. In addition: » Fear of particular people, places or activities, or of being attacked. » Behaving like a baby (wetting the bed or wanting parents to dress them). » Suddenly refusing to go to school. » Touching their private parts a lot. » Avoiding family and friends or generally keeping to themselves. » Refusing to eat or wanting to eat all the time.

COMMON SIGNS AND SYMPTOMS OF SEXUAL ABUSE ACCORDING TO AGE	
ADOLESCENTS (10–19)	<ul style="list-style-type: none"> » Depression (chronic sadness), crying or emotional numbness. » Nightmares (bad dreams) or sleep disorders. » Problems in school or avoidance of school. » Displaying anger or expressing difficulties with peer relationships, fighting with people, disobeying or disrespecting authority. » Displaying avoidance behavior, including withdrawal from family and friends. » Self-destructive behavior (drugs, alcohol, self-inflicted injuries). » Changes in school performance. » Exhibiting eating problems, such as eating all the time or not wanting to eat. » Suicidal thoughts or tendencies. » Talking about abuse, experiencing flashbacks of abuse.

In addition to the emotional, psychological and behavioral impacts of sexual abuse described in the signs and symptoms section above, children can face serious social consequences once they are identified as survivors of sexual abuse.

Children who are sexually abused may be rejected by their family and community, experience extreme social stigma, and/or suffer the loss of educational and employment opportunities. In addition, as sexually abused children age, they may see avenues for broader social acceptance and integration closing down. As a result, providing care to a child who has been sexually abused requires working with the family and community systems to address familial and social consequences. Different groups should implement community-based education and sensitization campaigns about sexual abuse in order to address any stigmatizing or shameful community practices toward children survivors of abuse. These types of community-based interventions can have a direct positive impact on sexually abused children successfully reintegrating into their communities.³⁴

KNOWLEDGE AREA 7: IMPACTS OF SEXUAL ABUSE ON CAREGIVERS

When non-offending caregivers first find out about their child being sexually abused, they will experience a wide range of feelings. The following emotional reactions are normal responses to a child disclosing sexual abuse. Caregivers may feel: anger, disbelief, shock, worry, deep sadness, and fear. Caregivers may not know what to do or where to seek help. They may want the problem to “go away” or not even realize that sexual abuse can cause harm and that their child

³⁴ This is an area of concern that requires study beyond the reach of these guidelines.

needs care. They may become angry and scold or beat the child. Some caregivers blame themselves for not paying attention to their child's behaviors or may feel they have failed as parents and have not protected their child. Some parents may wonder why their child chose to disclose to others and not them directly.

Some caregivers also feel conflicting emotions, especially if the accused perpetrator is someone that is a trusted and close friend or family member. Caregivers may experience betrayal, confusion and disbelief. In addition to a wide range of emotional experiences, parents may also experience insomnia, change of appetite or other physical complaints that are a result of the stress and fear associated with learning their child has been abused.

Caregivers also need support in coping after a disclosure of child sexual abuse, because they suffer emotionally and because the child needs the caregiver's support and attention to facilitate their own healing. Caregivers need to be aware that believing their child and standing by him or her is crucial for their child's recovery. Therefore, responding to cases of child sexual abuse requires service providers to have strategies and skills for positively involving non-offending caregivers in the child's healing and recovery.

KNOWLEDGE AREA 8: NEEDS OF CHILDREN AFTER SEXUAL ABUSE

Following the experience of sexual abuse, children may have immediate response needs that require service providers to mobilize crisis intervention support. Specifically, the need to ensure children's physical and emotional safety needs are met and access to timely health care is ensured.

Following the immediate crisis response, children may require additional care and support to help them recover and heal and to positively and fully engage in daily life. Longer-term needs include:

- » **Psychological Needs.** Children will need support to feel safe and trusting of adults again; to understand their feelings about the abuse; and to cope with post-traumatic stress symptoms that surface (flashbacks of the abuse, obsessive thoughts of the abuse, self-respect issues).
- » **Social Needs.** Children (and families) will need help to recover and heal from the impacts of sexual abuse on the family and familial relationships; to ensure that they are able to go back to school and participate in community and social events; and to develop and sustain positive and trusting relationships with peers and adults in the community.

- » **Care Arrangements.** Children will need a secure place to recover if abuse happened in the home and children cannot return.
- » **Legal/Justice Needs.** Children have a right to justice and may need support while the legal investigation and the prosecution of their cases occur.
- » **Other protection interventions.** Children who are separated or unaccompanied or who are facing other protection risks require targeted protection interventions.

KNOWLEDGE AREA 9: CHILDREN AND RESILIENCE³⁵

WHAT IS RESILIENCE?

“Resilience,” as defined by the Interaction Child Protection Task Team, is the ability of individuals, families and communities to endure and recover from adversities.³⁶ The IRC Child and Youth Protection and Development Unit defines a resilient child or youth as one who maintains or recovers his or her well-being despite experiencing adversity. A child’s resilience results from both individual characteristics and coping mechanisms (innate and acquired) and the protective factors in a child’s ecology or environment. These innate and acquired characteristics and mechanisms include biological, physical and psychological traits and health, as well as skills and knowledge. Children use these characteristics to defend themselves against violations of their rights and to cope with and recover from adversity.

External or environmental factors influence a child’s or youth’s resilience. The external conditions that enable children to endure and recover are known as protective factors. At the family level, these protective factors include positive attitudes and involvement on the part of parents or caregivers, family cohesion, adequate housing and stable and adequate income. At the community level, protective factors include involvement in community life, peer acceptance, supportive mentors, and access to quality schools and health care. It is essential for service providers to build on both a child’s individual coping mechanisms and protective environmental factors that support the healing and recovery of children following sexual abuse.

Working with child survivors requires service providers to be able recognize and build upon their resiliencies to help them cope with the impacts of sexual abuse. Identifying and building upon children (and families’ resiliencies) during service delivery is discussed in Chapter 6.

³⁵ The discussion of resiliency is drawn primarily from the IRC Child and Youth Protection and Development literature on children and resiliency.

³⁶ International Rescue Committee’s Child and Youth Protection and Development Sector Framework. A guide to sound project design and consistent messaging. January 2012.

KNOWLEDGE AREA 10: LOCAL CHILD PROTECTION MECHANISMS AND NORMS

Every community cares for its children and wants to protect them in principle. However, the ways in which communities protect children vary from community to community. Prior to working with child survivors in any community requires service providers to assess the child's environment, including the factors and actors that protect or pose risks to children. This requires learning about local norms, practices, and capacities, particularly in regards to child rearing. It also requires identifying and determining the protective capacities of individuals or groups in the community who may play an important role in a child's healing. Throughout the case management process, caseworkers should work closely with these individuals and groups, including children and families, to identify community resources, promote protective practices, and link child survivors and their families to the services and support they might need. Caseworkers should use their knowledge about local norms, practices and capacities to ensure that case management decisions address risks and capitalize upon protective factors that exist in families and communities. Specific information on this knowledge area should be developed locally.

DEVELOPING ADDITIONAL KNOWLEDGE AREAS AND ADAPTING TO CONTEXT

There may be additional knowledge areas related to child sexual abuse in the particular setting where services are being offered that are important for staff to know. In addition, information about sexual abuse may vary from one setting to another, based on population receiving services. For this reason, managers and supervisors are encouraged to build on and/or adapt the core knowledge areas outlined in this chapter. It is recommended that supervisors hold a meeting with 3-5 members of the local community to discuss local experiences and information about child sexual abuse services that are important for service providers to know. During this meeting, supervisors can also go through Knowledge Areas 1-10 and ensure that the information accurately represents the local context. In the Somali refugee camps, for example, it was deemed important for staff to understand the link between early marriage and sexual abuse. Therefore, the program included specific information related to Somali children's experiences with early marriage and sexual abuse. Staff are now assessed for their competency with regard to this knowledge.

Program managers and supervisors are responsible for improving the overall knowledge areas by making them more specific, wherever possible.³⁷

³⁷ This should happen prior to any training with service providers to ensure the most relevant and accurate knowledge concepts are conveyed and applied.

KEY FACTS TO REMEMBER

- » Sexual violence occurs throughout childhood, across contexts, cultures and classes.
- » Perpetrators are often people the child knows and trusts. This can result in abuse happening over a longer period of time and becoming more invasive over time.
- » Disclosure is a process. Children may not share all information at first; rather, their stories merge over time.
- » Children can heal. Caregivers and service providers can have a very positive impact on the healing process if they believe and support the children in their care.

GUIDELINES FOR ASSESSING AND MONITORING CORE KNOWLEDGE COMPETENCIES

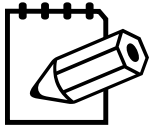
Service providers are required to demonstrate competency in the core knowledge areas outlined above.³⁸ Competency means that individuals are able to recall facts and information about children and child sexual abuse accurately and on their own. As noted already, technical understanding of child sexual abuse is fundamental to providing appropriate treatment and care. For example, service providers are responsible for understanding how a child's age and development affects their reactions to abuse and the particular dynamics of sexual abuse disclosure. In addition, service providers are responsible for educating children and families about sexual abuse during care and treatment and therefore, must have full and accurate information to do so.

The following methods for monitoring and assessing individual staff competency are:

1. implementing a knowledge assessment tool with individual staff;
2. directly observing individual staff providing services to children and providing feedback during individual and group case supervision.

The section below introduces a knowledge assessment tool to support managers and supervisors in assessing individual staff knowledge of the competency specific to the core knowledge competency areas outlined in this chapter.

³⁸ Health and/or psychosocial staff gain core knowledge through structured training and capacity building activities offered by their agency or another identified and competent agency in the field setting.



SUPERVISION TOOL: CCS KNOWLEDGE ASSESSMENT TOOL (CCS-KA)

The CCS Knowledge Assessment Tool (CCS-KA) is used by supervisors to measure an individual staff member's knowledge about child sexual abuse. This tool does not measure all knowledge competencies required to provide effective service (for example, knowledge areas on how to provide case management); rather, it measures technical knowledge of child sexual abuse core concepts. The CCS-KA Tool can be used with other staff assessment tools and checklists to monitor staff competencies. It provides a structured method for assessing knowledge competencies related to child sexual abuse to help identify areas where further capacity building is needed. The CCS-KA Tool is simple to implement. It should be administered following a formal training on child sexual abuse and, if possible, before working directly with children and families.

full tool at end of chapter

Supervision Tool Caring for Child Survivors Knowledge Assessment (CCS-KA)

Date:
Staff Name:
Supervisor:

Instructions for Administering the Tool

PURPOSE

This assessment tool represents the minimum standard technical knowledge competency areas required for health and psychosocial service providers working with child survivors of sexual abuse. Competent care rests on service providers understanding core child sexual abuse concepts. This is a staff supervision tool for supervisors to use with staff providing care directly to children and families.

INSTRUCTIONS

- (1) This supervision tool should be performed through a verbal interview between the staff and his/her supervisor in a quiet and confidential location.
- (2) The supervisor should inform the staff person this tool is being used to assess areas where further capacity building is needed. It is not a performance evaluation tool. The supervisor should explain they will receive a score to determine if individual staff member 'meets' the overall knowledge competency assessment.
- (3) The supervisor will ask the staff person to share his/her knowledge on the 20 topic areas in the tool. The supervisor will score the response accordingly.
 - **Met:** If the individual is able to answer the questions correctly and fully, they will receive a mark of 'met'.
 - **Partially Met:** If the individual is able to answer at least 50% of the question, they will receive a mark of partially met. For example, if the question is, "name 4 signs and symptoms of abuse" and the person can only name 2, they will receive a 'partially met' score.
 - **Unmet:** If the individual is unable to answer the question, they will receive a mark of 'unmet'.
- (4) Once the Assessment is complete, the supervisor will score the assessment and discuss with the staff member his/her score, what it means, and any further capacity building needed.

Administering the Tool

Knowledge Competency Area	Criteria for Answering Correctly	Met 2 pts	Partially Met, 1 pt	Not Met 0 pts
1. Explain the general definition of child sexual abuse	Need to make these main points for full score: 1. Must be able to describe who is considered a child (boy or girl under 18). 2. Must talk about using power over a child for sexual purposes. 3. Will likely start to describe specific acts of sexual abuse which you can also count as points towards the question below.			
2. What are the examples of sexual abuse that involves touching (contact)	Needs to be able to name at least two examples for full score: 1. Forced anal, vaginal or oral sex. 2. Touching a child's breast, buttocks or anus in a sexual way. 3. Forcing a child to touch private parts of another person for sexual purpose.			
3. What are the examples of sexual abuse that does NOT involve touching (non contact)	Needs to be able to name at least five examples for full score: 1. Forcing a child to watch sexual movies, read stories or look at sexual images. 2. A person showing their sexual parts to a child for sexual purposes (i.e. masturbating in front of a child). 3. Taking pictures of a child in sexual positions. 4. Making a child watch sexual acts on purpose. 5. Talking to a child in a sexual way. 6. Inappropriately watching a child undress or go to the bathroom (meaning doing this because the person is sexually gratified by doing this).			

Prior to implementing any new staff monitoring tools, it is advised that supervisors explain to their teams the purpose of implementing formal ways of assessing each staff person's competencies. Otherwise, staff members may become intimidated by the idea of their supervisor formally assessing their abilities. However, if supervisors explain that the purpose of competency assessments is to help identify areas where the individual can benefit from additional training and support, then staff generally feel more comfortable and will recognize the benefit for their professional growth.

USING THE CCS-KA TOOL

STEP 1

Set up an assessment interview between the supervisor and staff person being evaluated. The assessment interview should take place in a private and quiet space and will take between 30–60 minutes to complete.

STEP 2

Explain to the person being assessed that:

- » The purpose of the assessment is to measure specific knowledge on child sexual abuse in order to identify areas where additional training on child sexual abuse is needed.
- » He/she will not be penalized if he/she does not meet the competency assessment. However, he/she will need to demonstrate improved knowledge over time to avoid consequences.

Note: Supervisors should approach these assessment interviews in a friendly, supportive and relaxed manner. This does not mean the assessment is not taken seriously; rather, a friendly and supportive approach can help ease nervousness and fear a person may be feeling. This is not a performance review.

STEP 3

Implement the CCS-KA.

- » The CCS-KA is divided into 20 questions on child sexual abuse. The supervisor will verbally ask the individual the questions.

Administering the Tool					
Knowledge Competency Area	Criteria for Answering Correctly		Met 2 pts	Partially Met, 1 pt	Not Met 0 pts
1. Explain the general definition of child sexual abuse	Need to make these main points for full score	1. Must be able to describe who is considered a child (boy or girl under 18). 2. Must talk about using power over a child for sexual purposes. 3. <i>Will likely start to describe specific acts of sexual abuse which you can also count as points towards the question below.</i>			
2. What are the examples of sexual abuse that involves touching (contact)	Needs to be able to name at least two examples for full score	1. Forced anal, vaginal or oral sex. 2. Touching a child's breast, buttocks or anus in a sexual way. 3. Forcing a child to touch private parts of another person for sexual purpose.			

**CCS-KA
Answer Sheet**
(first page of tool)

1

CORE CHILD SEXUAL ABUSE KNOWLEDGE COMPETENCIES



HELPFUL TIP

The supervisor should be familiar with the questions asked prior to the assessment interview to allow for a free flowing conversation (while probing for answers to the specific questions), rather than a more formal Q&A interview format.

- » After asking about knowledge areas, the supervisor assesses the accurateness of the answers using the CCS-KA answer criteria. Answers are rated according to three possible levels:
 - **MET: 2 points** If the individual is able to answer the questions correctly and fully, they will receive a mark of “met.”
 - **PARTIALLY MET: 1 point** If the individual is able to supply at least 50% of the answer, he or she will receive a mark of “partially met.” For example, if the inquiry is, “Name four signs and symptoms of abuse,” and the person can only name two, they will receive a “partially met” score.
 - **UNMET: 0 points** If the individual is unable to answer the question, they will receive a mark of “unmet.”
 - **Note:** Only one mark is allowed. The supervisor will have to use his/her judgment along with the answer key to give a final rating.

STEP 4

Score the CCS–KA.

- » The supervisor should allow for 20–25 minutes following the interview to calculate the score.
- » The supervisor administering the tool will need to add up the points in each column and then total each column for a final score.
 - **30–40 points: MET** Scores in this range indicate that the staff person has met the core knowledge requirements and is able to work independently with children and families with ongoing supervision.
 - **16–28 points: PARTIALLY MET** Scores in this range indicate additional training is needed to build accurate and complete knowledge about child sexual abuse issues. The staff person should be monitored very closely if working on child sexual abuse cases. A capacity building plan should also be put into place. This may include one-on-one mentoring sessions, additional training opportunities, shadowing fellow staff members, among other capacity building activities.

- **0–14 Points: NOT MET** Scores in this range indicate that the staff person does not have sufficient knowledge to work on child sexual abuse cases. A capacity building plan should be put into place. This may include one-on-one mentoring sessions, additional training opportunities, shadowing fellow staff members, among other capacity building activities. Following additional training, the CCS-KA Tool should be re-administered.

TOTAL POINTS QUESTIONS 1-20			
TOTAL SCORE			
Evaluating Knowledge Competency – Instructions for Scoring: 30–40 points: MET: Scores in this range indicate that the staff person has met the core knowledge requirements and is able to work independently with children and families with ongoing supervision. 16–28 points: PARTIALLY MET: Scores in this range indicate additional training is needed to build accurate and complete knowledge about child sexual abuse issues. The staff person should be monitored very closely if working on child sexual abuse cases. A capacity building plan should also be put into place. This may include one-on-one mentoring sessions, additional training opportunities, shadowing fellow staff members, among other capacity building activities.	Final Evaluation: _____ MET _____ PARTIALLY Met _____ UNMET		

CCS-KA
Scoring Section
(last page of tool)

STEP 5

Review the score with the individual:

- » Review the final assessment score as soon as possible so the staff person need not be anxious about his/her performance. It is recommended the score be communicated to the staff person immediately following the assessment interview.
- » Review the correct and incorrect answers with the individual. Reassure and affirm the staff person on the knowledge areas he/she knows well. Answer any questions the individual may have; allow him or her to ask questions and share their thoughts and concerns.
- » Develop a plan for additional training and capacity building. This plan can be written into the CCS-KA Tool and the supervisor and staff person may keep a copy. The supervisor should store the CCS-KA results in a locked file in their personal file cabinets to protect the individual's confidentiality. Explain to the staff person where their assessment will be stored; explain their rights to confidentiality and make sure a plan is in place if they did not fully meet the competency.

ONGOING MONITORING

After the initial CCS-KA Tool has been administered to staff, it is recommended that it be re-administered every six months or as needed. This provides an opportunity to see if staff knowledge changes over time and to identify new areas or information that should be included in the assessment tool. In addition, service providers can engage in their own self-learning process, an important activity when working on cases as challenging as child sexual abuse.

DIRECT OBSERVATION AND SUPERVISION

In addition to administering the structured CCS-KA assessment, supervisors should identify opportunities to observe staff working with children and families. Direct observation allows supervisors to see how an individual applies knowledge about child sexual abuse in “real time.” Supervisors can not only look for accuracy, but also observe which techniques the staff member uses to communicate information effectively to children and families. If direct observation is not possible, supervisors can include specific questions to assess how knowledge was applied during casework as part of their regular supervision activities.

CONCLUSION

This chapter outlines the core child sexual abuse knowledge areas required for health and psychosocial service providers responding to cases of child sexual abuse. Accurate knowledge about child sexual abuse helps to ensure service providers share knowledge with children and families that is based on fact and not personal belief or opinion. Training health and psychosocial staff on the core knowledge concepts is an essential part of building the foundational skill set required to deliver appropriate services for child survivors. Children and families often ask questions to service providers about sexual abuse; it is important that service providers can respond to these questions in the moment and with accuracy. The knowledge areas and staff competency assessment tool outlined in this chapter will help to build the capacity of service providers in child sexual abuse specific knowledge.

Supervision Tool

Caring for Child Survivors Knowledge Assessment (CCS-KA)

Date:
Staff Name:
Supervisor:

Instructions for Administering the Tool

PURPOSE

This assessment tool represents the minimum standard technical knowledge competency areas required for health and psychosocial service providers working with child survivors of sexual abuse. Competent care rests on service providers understanding core child sexual abuse concepts. This is a staff supervision tool for supervisors to use with staff providing care directly to children and families.

INSTRUCTIONS

- (1) This supervision tool should be performed through a verbal interview between the staff and his/her supervisor in a quiet and confidential location.
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- (3) The supervisor will ask the staff person to share his/her knowledge on the 20 topic areas in the tool. The supervisor will score the response accordingly:
 - **Met:** If the individual is able to answer the questions correctly and fully, they will receive a mark of 'met'.
 - **Partially Met:** If the individual is able to answer **at least 50%** of the question, they will receive a mark of partially met. For example, if the question is, "name 4 signs and symptoms of abuse" and the person can only name 2, they will receive a 'partially met' score.
 - **Unmet:** If the individual is unable to answer the question, they will receive a mark of 'unmet'.
- (4) Once the Assessment is complete, the supervisor will score the assessment and discuss with the staff member his/her score, what it means, and any further capacity building needed.

Administering the Tool

Knowledge Competency Area	Criteria for Answering Correctly	Met 2 pts	Partially Met, 1 pt	Not Met 0 pts
1. Explain the general definition of child sexual abuse	Need to make these main points for full score <ol style="list-style-type: none"> 1. Must be able to describe who is considered a child (boy or girl under 18). 2. Must talk about using power over a child for sexual purposes. 3. <i>Will likely start to describe specific acts of sexual abuse which you can also count as points towards the question below.</i> 			
2. What are the examples of sexual abuse that involves touching (contact)	Needs to be able to name at least two examples for full score <ol style="list-style-type: none"> 1. Forced anal, vaginal or oral sex. 2. Touching a child's breast, buttocks or anus in a sexual way. 3. Forcing a child to touch private parts of another person for sexual purpose. 			
3. What are the examples of sexual abuse that does NOT involve touching (non contact)	Needs to be able to name at least five examples for full score: <ol style="list-style-type: none"> 1. Forcing a child to watch sexual movies, read stories or look at sexual images. 2. A person showing their sexual parts to a child for sexual purposes (i.e. masturbating in front of a child). 3. Taking pictures of a child in sexual positions. 4. Making a child watch sexual acts on purpose. 5. Talking to a child in a sexual way. 6. Inappropriately watching a child undress or go to the bathroom (meaning doing this because the person is sexually gratified by doing this). 			

4. What are the common types of sexual abuse in your work setting		1. This answer key should be developed in your context.			
5. Explain who are possible perpetrators of sexual abuse	Need to be able to make these main points for full score:	<ol style="list-style-type: none"> Children are most often abused by people the child knows and trusts. Also mention that children can perpetrate sexual abuse against other children. Strangers can also sexually abuse. Other fact that is specific to context. 			
6. Explain the reasons why a child may not tell anyone about sexual abuse	Need to be able to identify at least 6 reasons for full score:	<ol style="list-style-type: none"> Fear of being hurt. Threatened by perpetrator. Fear of being blamed. Not knowing what happened was abuse. Protecting family /parents. Shame and guilt. Manipulation (given something in exchange for not telling). Additional reason specific to population/cultural context. 			
7. Define direct and indirect disclosure	Need to be able to identify these points for full score:	<ol style="list-style-type: none"> Direct disclosure is when the child survivor or the child survivor's family members/friends directly shares about the abuse. Indirect disclosure is when someone witnesses the sexual abuse to the child, or if the child contracts a sexually transmitted disease or the child becomes pregnant. 			
8. Why is it important to know how sexual abuse was first found out (i.e. disclosed)	Need to be able to identify these 3 points for full score:	<ol style="list-style-type: none"> To know whether or not the child was 'willing' for the sexual abuse to be disclosed. To know if the child told someone already, to identify this person as a possible person of trust. To know whether or not the primary caregiver is aware, as this will affect how the care and treatment is coordinated with the family. 			
9. List the common signs and symptoms of sexual abuse for children ages 0-5	Need to be able to identify at least 5 signs and symptoms for full score:	<ol style="list-style-type: none"> Crying, whimpering, screaming that is not usual behavior Trembling, fearful. Not wanting to separate from caregivers, may be more attached than normal. May not want to leave places they feel safe. Sleeping problems. Problems developing, such as losing ability to talk. 			
10. List the common signs and symptoms of sexual abuse for children ages 6-9	Need to be able to list at least 6 signs and symptoms for full score:	<ol style="list-style-type: none"> Fear of particular people, places or activities. Behaving like a baby (e.g., going to the bathroom in bed or wanting parents to dress them). May refuse to go to school. Touching their private parts a lot. Feelings of sadness. Nightmares (very bad dreams) or problems sleeping. Stay alone and away from family or friends. Eating problems, such as not wanting to eat or wanting to eat all the time. Additional reactions that are common to population/cultural context. 			
11. List the common signs and symptoms of sexual abuse for children ages 10-18	Need to be able to list at least 6 signs and symptoms for full score	<ol style="list-style-type: none"> Depression, sadness, crying. Nightmares. Problems in school (hard to concentrate). Withdrawing from friends and community activities Anger and fighting. Think about the abuse all the time, even when they don't want to. Thoughts of wanting to die; attempted suicide. Additional reactions that are common to population/cultural context. 			

12. What are common social consequences of sexual abuse for a child	Need to be able to identify at least 4 consequences for full score:	<ol style="list-style-type: none"> 1. Shunned by family and/or community. 2. Blamed by family/community. 3. Stigmatization and being 'outcast'. 4. Seen as a 'bad girl' or a 'homosexual boy'. 5. Other culturally relevant reason. 			
13. What are common health consequences of sexual abuse for a child?	Need to be able to identify at least 8 health consequences for full score:	<ol style="list-style-type: none"> 1. Injury (bruises, broken bones, vaginal injuries). 2. Disease / Infection. 3. Chronic Infections. 4. Chronic Pain. 5. Gastrointestinal problems. 6. Sleep Disorders. 7. Unwanted Pregnancy. 8. Unsafe Abortion. 9. STIs including HIV. 10. Menstrual disorders. 11. Pregnancy complications. 12. Gynecological disorders. 			
14. What are the four main areas of need a child will have immediately after sexual abuse?	Need to name all 4 to receive full credit:	<ol style="list-style-type: none"> 1. Safety Needs. 2. Health Needs. 3. Psychosocial Needs, and 4. Legal Justice Needs. 			
15. What are some special considerations related to boy child survivors	Need to make these 4 points for full score:	<ol style="list-style-type: none"> 1. Boys can be sexually abused. 2. Boys may have an even harder time disclosing. 3. Boys may experience deep shame and/or fear that sexual abuse causes homosexuality. 4. Other point provided that is relevant to the cultural context. 			
16. What are the factors that can make sexual abuse more serious	Need to be able to list at least 5 factors for full score:	<ol style="list-style-type: none"> 1. Age of the abuse. 2. If violence was used. 3. How long the abuse went on (longer = worse). 4. the relationship the child has to the perpetrator (closer relationship = worse). 5. What happened after the abuse. For example, was the child believed and helped? (not believed = worse) 6. Other fact that is specific to context. 			
17. What are some common feelings caregivers may have after hearing about their child being sexually abused	Need to list at least 5 feelings below for full score:	<ol style="list-style-type: none"> 1. Blaming themselves for the abuse. 2. Fear for their child's health and safety. 3. Guilt and shame. 4. Anger at their child. 5. Misunderstanding their child, for example, thinking child is lying. 6. Other reaction provided that is relevant to the cultural context. 			
18. What can help to promote children's coping and healing.	Need to list at least 5 factors for full score:	<ol style="list-style-type: none"> 1. Caring and timely support. 2. Family and social support and care. 3. Ability to continue with education and other activities the child was involved in prior to the abuse. 4. Psychosocial interventions that help the child understand and manage their reactions to the abuse. 5. Individual capacity of the child. 6. Religious or spiritual beliefs. 7. Other that is specific to the context. 			



Chapter Two

CORE CHILD-FRIENDLY ATTITUDE COMPETENCIES

This chapter applies to health and psychosocial service providers.

CONTENTS OF THIS CHAPTER INCLUDE

- » Core child-friendly attitude competencies.

TOOLS IN THIS CHAPTER INCLUDE

- » Caring for Child Survivors Attitude Scale (CCS-Attitude Scale) Tool

CHAPTER OVERVIEW

This chapter outlines core child-friendly attitude competencies that staff working with child survivors must possess. Possessing a child-friendly attitude is essential when working with children and families in a response capacity.³⁹ In addition to outlining the core child-friendly attitude competencies, this section introduces a supervision tool, the CCS Attitude Scale, to assist supervisors/managers in evaluating staff attitudes toward children and specifically, children who have been sexually abused.

³⁹ Additional competency areas are required for specific service providers (health and/or psychosocial) as outlined in other chapters of the guidelines.

“Any person working with people who have been raped or sexually abused should be aware of the differences between myth and fact. Personal beliefs and attitudes toward rape need to be examined and challenged.”

WHO Guidelines for medico-legal care for victims of sexual violence

CORE ATTITUDE COMPETENCIES REQUIRED IN SEXUAL ABUSE RESPONSE

In cases of child sexual abuse, the attitude (values and beliefs) of the service provider can have a direct impact on a child's healing and recovery. Research shows that children can be positively or negatively affected based on the response of the person helping them.⁴⁰ Because service providers play such a key role in promoting (or not promoting) a child's healing and recovery, they must have a solid foundation of positive attitudes about children and child sexual abuse survivors in order to provide compassionate care and not to harm. Simply put, harmful attitudes are unacceptable for service providers because they can prevent the recovery for all people involved.

In addition, service providers are in the position to educate important and influential adults in a child's life. Adults, especially family members, need to understand that dismissing a child's revelation of sexual abuse or blaming a child for such abuse, is harmful. Service providers must challenge such attitudes and practices among adults if they are to facilitate understanding and empathy for the affected child.

Therefore, staff providing direct care to children must be assessed for harmful attitudes to ensure no further harm is done to a child.

⁴⁰ Perry, B. (2007). *The boy who was raised as a dog: And other stories from a child psychiatrist's notebook: What traumatized children can teach us about loss, love, and healing*. New York: Basic Books.

CORE CHILD-FRIENDLY ATTITUDE COMPETENCY AREAS

Health and psychosocial service providers must have the ability and commitment to put the following child-friendly values and beliefs into practice, and to ensure child-friendly attitudes are communicated during the provision of care. The overarching values that are essential for service providers working with children include the recognition that:

- » Children are resilient individuals.
- » Children have rights, including the right to healthy development.
- » Children have the right to care, love and support.
- » Children have the right to be heard and be involved in decisions that affect them.
- » Children have the right to live a life free from violence.
- » Information should be shared with children in a way they understand.

In addition, there are specific beliefs that are absolutely vital for service providers to have when working with child sexual abuse survivors. They include the belief that:

- » Children tell the truth about sexual abuse.
- » Children are not at fault for being sexually abused.
- » Children can recover and heal from sexual abuse.
- » Children should not be stigmatized, shamed, or ridiculed for being sexually abused.
- » Adults, including caregivers and service providers, have the responsibility for helping a child heal by believing them and not blaming them for sexual abuse.

These child-friendly values and beliefs are certainly not an exhaustive list; however, they represent the minimum standard for adults working with children in a response capacity. Skill and knowledge mean nothing if they are not delivered in a caring and compassionate manner; this rests on individual attitudes.

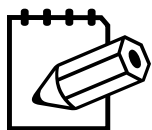
It is important to remember that culture and societal norms directly affect service providers' attitudes, and supervisors should be sensitive to the fact that beliefs and values don't always match the highest standards required to help child survivors recover and heal. While changing traditional attitudes is a process and should take place in a supportive environment, it may also be necessary for certain individuals to not work directly with children until they are able to embrace the core values and beliefs outlined in this chapter.

GUIDELINES FOR ASSESSING AND MONITORING CORE ATTITUDE COMPETENCIES

Health and psychosocial service providers should undergo an attitude assessment prior to working directly with children and families. Supervisors can use personal attitude assessments as a staff development tool to ensure that staff have the values and beliefs which will help children and families heal from sexual abuse. Supervisors and program managers are responsible for ensuring high quality care and action is required when poor staff attitudes negatively affect a child's well-being.

There are different methods for evaluating staff attitudes; the following two are recommended:

1. using the CCS Attitude Scale to assess belief and values,
2. directly observing staff and giving feedback on examples of good and bad practice during individual and groups case supervision.



SUPERVISION TOOL: THE CCS ATTITUDE SCALE

The CCS Attitude Scale is a tool for supervisors to evaluate attitudes amongst staff providing direct support to children who have been abused. The CCS Attitude Scale includes 14 statements about child sexual abuse that aim to assess personal values and beliefs. If needed, additional attitude competencies and/or questions can be added to the CCS Attitude Scale to better match values, attitudes and beliefs in a particular context or setting. The CCS Attitude Scale monitors an individual's attitudinal readiness for working directly with children, while also highlighting specific areas of focus for future training and education.

WHEN TO ADMINISTER

The CCS Attitude Scale can be administered in conjunction with the CCS Knowledge Assessment (CCS-KA). Ideally, the CCS Attitude Scale is given prior to staff working directly with child survivors.

HOW TO ADMINISTER

STEP 1

Set up a private, comfortable setting where the individual has at least 30 minutes to complete the personal assessment. The CCS Attitude Scale should not be given as homework or in other ways that would allow someone to consult with others. This is a personal assessment.

full-size tool at end of chapter

STEP 2

Explain the purpose. Supervisors should clearly explain to staff that this is an assessment to better understand their personal beliefs and feelings about sexual abuse. Emphasize to staff that all answers should be honest and self-reflective, and that the CCS Attitude Scale is a tool to identify areas where individuals can benefit from further coaching and staff development.

Supervision Tool: CCS Attitude Scale

Date: _____
Staff Name: _____

Supervisor: _____

Purpose and Instructions

PURPOSE: The practice of quality, empowering, and strengths-based care for children and families affected by sexual abuse requires that service providers recognize and are committed to upholding certain truths at the outset of working directly with children. Staff should exhibit child-friendly beliefs and attitudes in order to effectively provide compassionate and appropriate care and treatment to child survivors.

INSTRUCTIONS:

- 1) This is a self-administered tool. Meaning the supervisor will give the CCS Attitude Scale to the staff person working directly with child survivors and the staff person will complete on their own and return to the supervisor when finished.
- 2) The supervisor should explain that the questionnaire should be answered by the staff person only, and he/she should answer the questions as honestly as possible.
- 3) The CCS Attitude scale is divided into 14 questions aimed to get at a person's underlying feelings and beliefs about children and sexual abuse. The individual will score themselves how much they agree or disagree with a question on a scale of 1 through 4.
- 4) This assessment tool should be administered AFTER the staff receives training on child sexual abuse and BEFORE the staff starts to work directly with children. The CCS Attitude Scale should be administered regularly to gauge any changing attitudes and beliefs as staff working with child survivors.

NOTE: This Attitude Scale is not the only way for supervisors to monitor staff's attitude and behavior working with child survivors. In addition to using this tool, supervisors should observe counseling sessions with children to evaluate the staff person's ability to communicate healing attitudes to children.

Statements	Individual Scoring			
	Strongly Agree	Somewhat Agree	Somewhat Disagree	Strongly Disagree
1. Children have something to offer the community.	4	3	2	1
2. Sexual abuse can be the child survivors fault.	1	2	3	4
3. Children should keep silent and not talk about sexual abuse.	1	2	3	4
4. Sexual abuse is always the perpetrators fault.	4	3	2	1
5. Children who are sexually abused are dirty and ruined.	1	2	3	4
6. It is my responsibility to hold adults and caregivers accountable when they blame children who have experienced sexual abuse.	4	3	2	1
7. Sexual abuse <u>does not</u> cause homosexuality.	4	3	2	1
8. Making a child feel shame and guilt after sexual abuse is sometimes okay.	1	2	3	4
9. I am responsible for believing and supporting children who are sexually abused, no matter what the community thinks.	4	3	2	1
10. A child may purposefully make up stories about being sexually abused.	1	2	3	4
11. Children can be sexually abused by a close relative.	4	3	2	1
12. Children deserve kindness, support and care after sexual abuse and this is my responsibility.	4	3	2	1
13. It is my responsibility to be aware of my own beliefs and values about sexual abuse and to talk to my supervisor if I find that I am blaming or judging children.	4	3	2	1
14. Children who are sexually abused CANNOT heal and recover and live a normal life.	1	2	3	4
For the Supervisor: Add up the number of points in each column, and then add each column together for the TOTAL SCORE.				
TOTAL SCORE				

STEP 3

Explain how to do it. The CCS Attitude Scale is divided into 14 questions aimed to identify a person's underlying attitudes (feelings and beliefs) about children and sexual abuse. Individuals will score themselves whether they agree or disagree with a question—based on a scale of 1 through 4.

STEP 4

Have the individual complete the CCS Attitude Scale in a quiet and comfortable setting.

2 CORE CHILD-FRIENDLY ATTITUDE COMPETENCIES

STEP 5

Score the CCS Attitude Scale. Each question was devised so that answers can range from a positive high of 4 to a negative low of 1. Guidelines for interpreting the scores are listed below:

- » **56–46 Points:** Scores in this range indicate that the helper has a child-friendly attitude—they have positive beliefs and values for working with children.
- » **45–35 Points:** Scores in this range indicate some troubling attitudes that may be harmful to children. Managers and supervisors should use their discretion in allowing staff to work on child sexual abuse cases and may want to consider “coaching” the staff person before they work independently with child survivors.
- » **34 Points and Below:** Scores in this range indicate that a helper is not ready to work with sexually abused children. Managers and supervisors should work independently with an individual who scores below 34 to address negative beliefs and attitudes and identify remedial actions.

STEP 6

Explain the results. Supervisors should communicate scores to staff as soon as possible to decrease their anxiety about performance.

Review the results with the staff member and discuss any troubling attitudes that were revealed during the self-assessment.

If the staff member does not meet, or only partially meets the required attitudes for working with child survivors, discuss with the individual whether he or she feels ready to work with child clients before engaging in additional self-reflection and/or training. It may not be appropriate for the individual to work with children until he or she undergoes personal reflection of the harmful values and/or beliefs discovered during the attitude assessment. If this is the case, supervisors will need to handle this conversation carefully and sensitively. In some settings, it may be required to discuss these results with a senior manager for advice on how to approach the conversation.

MONITORING ATTITUDES

The CCS Attitude Scale should be administered to individuals prior to working on cases of child sexual abuse. Following the initial evaluation, supervisors should administer the CCS Attitude Scale or another attitude assessment tool developed in your setting. This provides an opportunity to discover whether service providers' attitudes are changing, either in a positive or negative way. Service providers may thus engage in their own self-awareness process when working on cases as challenging as child sexual abuse.

Supervision Tool: CCS Attitude Scale

Date:

Supervisor:

Staff Name:

Purpose and Instructions

PURPOSE: The practice of quality, empowering, and strengths-based care for children and families affected by sexual abuse requires that service providers recognize and are committed to upholding certain truths at the outset of working directly with children. Staff should exhibit child-friendly beliefs and attitudes in order to effectively provide compassionate and appropriate care and treatment to child survivors.

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14. Children who are sexually abused CANNOT heal and recover and live a normal life.	1	2	3	4
For the Supervisor: Add up the number of points in each column, and then add each column together for the TOTAL SCORE.				
TOTAL SCORE				



Chapter Three

CORE SKILLS: ENGAGING AND COMMUNICATING WITH CHILD SURVIVORS

This chapter is for health and psychosocial service providers.

CONTENTS OF THIS CHAPTER INCLUDE

- » Best Practices for Communicating with Child Survivors
- » Guidelines for Talking with Child Survivors about Sexual Abuse
- » Verbal and Non-Verbal Communication Techniques
- » Strategies for Addressing Common Communication Challenges

TOOLS IN THIS SECTION

- » Supervision Tool: CCS Communication Assessment (CCS-CA)

CHAPTER OVERVIEW

This chapter applies to health and psychosocial service providers working with children and families affected by sexual abuse. It introduces best practices for communicating and engaging children who have experienced child sexual abuse. It also includes step-by-step guidance on how to conduct an interview with a child survivor about his/her experience of sexual abuse. Service providers must possess specialized skills in child-centered communication to effectively care for child survivors. Their work, whether as health workers or psychosocial workers, requires them to exchange information with children efficiently and effectively.

DEVELOPING A HELPING RELATIONSHIP THROUGH SAFE AND HEALING COMMUNICATION

HELPING RELATIONSHIPS

The goal of communication between a service provider and child is to establish a trusting, safe and supportive **helping relationship**.

The helping relationship is a relationship of trust that empowers the child and caregiver(s) to feel cared for and respected by the service provider. Every meeting with child survivors and family members are opportunities for service providers to strengthen the helping relationship.

Effective communication skills are fundamental to delivering good care. The heart of compassionate and effective service provision relies on the service provider having the appropriate knowledge, attitudes and skills to communicate trust, comfort and care to children. It is through the dynamic process of communication (verbal and non-verbal) that positive, helpful relationships are developed and healing starts to occur. Evidence⁴¹ shows that health and psychosocial service providers can impact a child's healing based on their responses to a child's disclosure of abuse—in other words, what service providers say and how they say it. For example, if a child discloses sexual abuse and perceives he/she is being blamed for the abuse by the service provider, the child may experience deeper levels of shame, anxiety and sadness. This may result in the child refusing to share further information or even deny the abuse altogether in subsequent interviews because he/she does not feel safe. However, if a service provider communicates immediate belief, care and empathy, the child survivor may be willing to engage further, thus helping the provider to offer appropriate care and treatment.

It is a common mistake to assume that children (from the age of six or so) are too young to be aware of what is going on around them or too young to be adversely affected by dangerous or distressing experiences such as sexual abuse. Children who have experienced abuse may find it extremely difficult to talk to others about what they have experienced. Some will find it difficult to trust adults, especially those they do not know well. Others will be afraid of being overwhelmed by their emotions if they express them to

⁴¹ Perry, B. *The Boy Who Was Raised as a Dog, and Other Stories from a Child Psychiatrist's Notebook: What Traumatized Children Can Teach Us About Loss, Love, and Healing*. New York: Basic Books, 2007.

an adult, while some may use particular behaviors to “test out” whether adults will react critically or sympathetically toward them. For example, children may refuse to speak or they may react strongly (yell or scream) when questioned.

The ability to communicate effectively with children is crucial to sharing information, as well as for encouraging further communication and protecting and assisting these children. Accurate and truthful information can be empowering to children and facilitates their involvement in subsequent decision-making.

As outlined in Chapter 1, some children will feel guilty or ashamed about sexual abuse, especially if they feel in some way responsible for what has happened. Such feelings make it especially difficult for them to talk about what has happened. Effective and compassionate communication is integral to child-centered care and has the additional function of supporting psychological healing from sexual abuse-related trauma. Service providers can promote healing simply through the manner in which they communicate with the child survivor. For example, a caseworker who effectively communicates that he/she believes the child, that the sexual abuse is not the child's fault, and that the child has done the right thing by disclosing abuse is providing a key psychosocial intervention: believing and validating the child.

BEST PRACTICES FOR COMMUNICATING WITH CHILD SURVIVORS

Health and psychosocial service providers responding to child sexual abuse cases should adhere to the following set of communication best practices while working with children who have been sexually abused. While specific communication techniques will need to be adapted according to a child's age and developmental stage, the core communication principles outlined below should guide communication, regardless of the child's age, gender or cultural context. They can be applied in multiple types of interview/communication contexts, including:

- » forensic interviews conducted by health workers or police,
- » medical interviews conducted by health workers,
- » and child intake and assessment interviews conducted by caseworkers.

3 CORE SKILLS: ENGAGING AND COMMUNICATING WITH CHILD SURVIVORS



Photo: Abigail Erikson/the IRC

Any service provider talking with children affected by abuse should adhere to these guiding principles, regardless of the purpose of the communication, in order to ensure that children are not further traumatized during communications with service providers.⁴²

1. Be Nurturing, Comforting and Supportive

Children who have been sexually abused most likely will come to your attention through a caregiver or another adult; abused children rarely seek help on their own. Children may not understand what is happening to them or they may experience fear, embarrassment or shame about the abuse, which affects their willingness and ability to talk to service providers. Your initial reaction will impact their sense of safety and willingness to talk, as well as their psychological well-being. A positive, supportive response will help abused children feel better, while a negative response (such as not believing the child or getting angry with the child) could cause them further harm.

2. Reassure the Child

Children need to be reassured that they are not at fault for what has happened to them and that they are believed. Children rarely lie about being sexually abused and service providers should make every effort to encourage them to share their experiences. Healing statements such as “I believe you” and “It’s not your fault” are essential to communicate at the outset of disclosure and throughout care and treatment.

⁴² There are more specific forensic interview guidelines for aiding responders in the law enforcement and health sectors. If applicable, they should be known and followed. These guidelines are most relevant to service providers who conduct intake and assessment interviews in the context of case management and health care.

Direct service providers communicating with child survivors need to find opportunities to tell them that they are brave for talking about the abuse and that they are not to blame for what they have experienced. It is required for service providers to tell children that they are not responsible for the abuse and to emphasize that they are there to help them begin the healing process.

3. **Do NO Harm: Be Careful Not to Traumatize the Child Further**

Service providers should monitor any interactions that might upset or further traumatize the child. Do not become angry with a child, force a child to answer a question that he or she is not ready to answer, force a child to speak about the sexual abuse before he/she is ready, or have the child repeat her/his story of abuse multiple times to different people. Staff should try to limit activities and communication that cause the child distress.

4. **Speak So Children Understand**

Every effort should be made to communicate appropriately with children; information must be presented to them in ways and language that they understand, based on their age and developmental stage.

5. **Help Children Feel Safe**

Find a safe space, one that is private, quiet and away from any potential danger. Offer children the choice to have a trusted adult present, or not while you talk with them. Do not force a child to speak to, or in front of, someone they appear not to trust. Do not include the person suspected of abusing the child in the interview. **Tell the child the truth—even when it is emotionally difficult.** If you don't know the answer to a question, tell the child, "I don't know." Honesty and openness develop trust and help children feel safe.

6. **Tell Children Why You Are Talking with Them**

Every time a service provider sits down to communicate with a child survivor, she should take the time to explain to the child the purpose of the meeting. It is important to explain to the child why the service provider wants to speak with them, and what will be asked of the child and his/her caregiver. At every step of the process, explain to children what is happening to help secure their physical and emotional well-being.

HEALING STATEMENTS

"I believe you."

BUILDS TRUST

"I am glad that you
told me."

BUILDS A RELATIONSHIP
WITH THE CHILD

"I am sorry this happened
to you."

EXPRESSES EMPATHY

"This is not your fault."

NON-BLAMING

"You are very brave to
talk with me and we will
try to help you."

REASSURING AND
EMPOWERING

3 CORE SKILLS: ENGAGING AND COMMUNICATING WITH CHILD SURVIVORS

7. Use Appropriate People

In principle, only female service providers and interpreters should speak with girls about sexual abuse. Male child survivors should be offered the choice (if possible) to talk with a female or male provider, as some boys will feel more comfortable with a female service provider. The best practice is to ask the child if he or she would prefer to have male or female trained staff on hand.

8. Pay Attention to Non-Verbal Communication

It is important to pay attention to both the child's and your own non-verbal communication during any interaction. Children may demonstrate that they are distressed by crying, shaking or hiding their face, or changing their body posture. Curling into a ball, for example, is an indication to the adult working with the child to take a break or stop the interview altogether. Conversely, adults communicate non-verbally as well. If your body becomes tense or if you appear to be uninterested in the child's story, he or she may interpret your non-verbal behavior in negative ways, thus affecting his or her trust and willingness to talk.

9. Respect Children's Opinions, Beliefs and Thoughts

Children have a right to express their opinions, beliefs and thoughts about what has happened to them as well as any decisions made on their behalf. Service providers are responsible for communicating to children that they have the right to share (or not to share) their thoughts and opinions. Empower the child so he/she is in control of what happens during communication exchanges. The child should be free to answer "I don't know" or to stop speaking with a service provider if he/she is in distress. The child's right to participation includes the right to choose not to participate.



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GUIDELINES FOR COMMUNICATING WITH CHILDREN ABOUT THEIR EXPERIENCE OF SEXUAL ABUSE

Sexual abuse can be a traumatic experience for children, and talking about abusive experiences can trigger feelings and emotions that the child experienced during the actual abuse. Service providers must be aware of this and handle conversations about sexual abuse with sensitivity. Service providers need to talk to boys and girls about their experiences of sexual abuse in order to understand what happened and to direct care and treatment.⁴³ Often, children and caregivers will be in crisis during the initial intake and assessment interviews and service providers are responsible for knowing how to create a safe, supportive and caring environment. In addition to adhering to the communication best practices, the following recommendations for handling interviews should be followed.

SETTING THE STAGE: CREATING A SAFE ENVIRONMENT

Service providers are responsible for ensuring that children's emotional and physical safety are safeguarded during all communications with children, particularly during direct interviews about experiences of sexual abuse. The following strategies can help to create a feeling of safety, which is essential for children expected to share personal and painful experiences with service providers.⁴⁴

CREATING A SAFE AND SUPPORTIVE ENVIRONMENT

- 1. Choose a safe location.** Interviews with children should take place in a confidential, safe and child-friendly atmosphere. A child-friendly atmosphere can include child-friendly toys and materials or a space to sit comfortably on the floor.
- 2. Explain who you are.** A GBV social worker, health worker, law enforcement officer or child protection staff person is in a position different from that of parents or teachers.

⁴³ The practice of multiple interviews has been shown to cause additional trauma to child survivors. In Chapter 7: Recommendations for Coordination in Cases of Sexual Abuse, we offer suggestions to service providers on how to best to coordinate multiple interviews.

⁴⁴ This section is adapted from the U.N. International Children's Fund (UNICEF), Training Manual on Caring for Survivors, created 2004 and updated 2010. Formal Reference: IASC Training Manual on Caring for Survivors, United Nations International Children's Fund (UNICEF) (2010).

3 CORE SKILLS: ENGAGING AND COMMUNICATING WITH CHILD SURVIVORS

All service providers must identify the organization they represent and explain their role and the purpose of the meeting. Below is an example of a service provider working with a psychosocial agency.



“My name is Asha and my job is to help girls and boys when they feel sad or have any problems. The name of my organization is Safe Places and we have six other women here who also help children and other people. My job is to keep you safe and to listen to you, and give you information about how to get help if you need it.”

3. **Obtain permission.**⁴⁵ Talking with children about sexual abuse requires permission from them and their caregivers. However, permission can depend on the child's age and circumstances. If the caregiver or another adult responsible for the child is the suspected abuser, the service provider should seek permission from another responsible and safe adult, for example the person who brought the child in for help. If the person who brought the child in is not the caregiver, and the caregiver is not deemed to be a threat, every effort should be made to locate the caregiver and obtain their consent before proceeding with intake and assessment interviews and other aspects of service. For detailed instructions on how to obtain permission or “informed consent/assent,” please reference Chapter 5.
4. **Maintain equality.** Sit at the same height as the child; keep your eyes aligned with the child's eyes. Try not to bend over or look down at the child, or squat to look up into the child's face. These strategies promote a sense of respect for the child and reinforce feelings of trust.
5. **Ask for permission to speak.** Ask children above the age of seven for permission to speak with them. While children may not be able to give legal consent, they have the ability to “assent” to being asked about their experiences.⁴⁶ Children have the right to express their views and opinions, and seeking permission from children to ask questions demonstrates the service provider's respect of their rights.
6. **Explain what will happen.** The service provider should explain what will happen and what the child's rights are during the session. This helps children know what to expect and what they can control. For example, children have the right to stop the interview at any time or not answer a question. Children have the right to make mistakes and should be allowed to change their minds. Children rarely end conversations arbitrarily, but they and their parents feel safer if they know they can. Finally, it never hurts to remind children that there are no right or wrong answers. You are only interested in their experiences and ideas.

⁴⁵ Specific guidance explaining how to obtain permission or informed consent/assent during service delivery is outlined in Chapter 5.

⁴⁶ This concept and practice of obtaining child informed assent is covered in depth in Chapter 5.



Illustration by Abdifatah Abdukadir Osman

7. **Explain the process.** Explain the purpose of your meeting in child-friendly terms. Either before, during or after the general discussion, tell the child, using language he or she will understand, how the information he or she provides might need to be shared. Tell the child you want to hear about their experience and be as specific as you can. For example, tell the child about other people (“families,” “kids your age,” “people like you”) who have had the same kind of thing happen to them and how they have found it helpful to talk to others.
8. **Talk with the child with trusted adults.** To the greatest extent possible during any intake and/or assessment, children should have a trusted adult with them, especially very young children and children who are afraid of the service provider. During the assessment phase, there may be times when it is appropriate to talk to children and parents separately, but if the parent(s) are not suspected perpetrator(s) and children want them in the room, they should be included. On the other hand, some children will hesitate to speak in front of parents and service providers will need to consider talking with them alone.
9. **Do not make promises you cannot keep.** A child may say, “I have something I need to tell you but you have to promise to keep it a secret.” The child’s trust has most likely been broken already by someone close to him or her. It is important to reassure them that they can trust you, but **also to inform them that you might need to share some of the information they provide in order for you to keep them safe.** If the child discloses he or she is being hurt and is unsafe, you must tell others who need to know, and the child should know that you cannot keep this information confidential.

3 CORE SKILLS: ENGAGING AND COMMUNICATING WITH CHILD SURVIVORS

10. Don't force or pressure the child to talk. It is better to go slowly and not to ask for too much information too quickly. Children may become flooded with feelings of fear when discussing their experiences of abuse and service providers should stop if the child appears distressed. Follow-up conversations with children who become distressed are not considered "multiple interviews." At all times, the child should set the pace of the conversation, not the service provider.



HELPFUL TIPS: CHILDREN, MEMORY AND EMOTION

- » The experience of trauma can affect a child's ability to remember what happened and pass on information during an interview.
- » Children may not connect emotionally with the story they are retelling in the same way adults might. Children may have no emotional reaction at all, while others will react emotionally in a way that mimics the person talking with the child. This is why it is important for service providers to remain calm, in control and comforting.

USING VERBAL AND NON-VERBAL COMMUNICATION TECHNIQUES

Service providers need to employ various techniques to help facilitate communication according to age and developmental levels. Service providers should be skilled in verbal and non-verbal communication techniques, as some children may not be able to find the words to share important information—because of age or because the challenge of recalling the trauma is overwhelming.

This section walks through effective verbal and non-verbal techniques for gathering important information from children in a caring and compassionate manner. The techniques described in this section, along with the above-mentioned communication practices will help service providers create feelings of trust and safety for children being assessed and/or interviewed. These techniques are not considered counseling; however, these same kinds of engagement strategies are in-line with child-friendly counseling guidelines.

CHILD-FRIENDLY COMMUNICATION TECHNIQUES⁴⁷

Children, ages six years and older, who are able to communicate verbally can benefit from service providers who implement the following strategies:

⁴⁷ This section draws heavily from the IASC Training Manual on Caring for Survivors, United Nations International Children's Fund (UNICEF). (2010).

- » Talk with children about their life, school, family and other general topics before asking direct questions about their experience(s) of abuse. This helps the service provider to gauge the child's capacity to be verbal and helps a child feel at ease with the service provider.
- » Use as many open-ended questions as possible. Avoid multiple-choice or yes/no questions, which can be confusing and lead the child to give inaccurate responses.
- » Avoid using the words “why” or “how come.” This will result in answers frustrating for you and the child: “I don’t know,” for example, or a shrug of the shoulders, or silence. Instead, ask for the child’s opinion as to why something is so: “What do you think the reason is...?” In addition, “why” questions can come across as blaming, such as “Why didn’t you...” for example.
- » Use words that encourage the child to continue talking:
 - “Tell me more about that...”
 - “What do you mean by...”
 - “Give me an example of...” or “Describe for me...”
 - “Go on...”
 - “And then what happened...?”
- » Don't put words in the child's mouth. Whether using verbal or non-verbal techniques (see below for guidance on using non-verbal techniques), service providers need to be careful not to put words in a child's mouth. For example, do not say, “Did he put his hands on your breasts?” Or if using a doll to help a child communicate what happened, do not point to the breasts on the doll and ask, “Did he touch you here?” Instead, ask the child to show you where he/she was touched. Other examples of useful questions or statements:
 - Has anyone ever touched you in a way that makes you confused or frightened?
 - Share with me how you were touched.
 - Tell me what happened next.
 - Use your own words. It is okay to go slowly.
- » Choose the right words. Children, especially those under the age of six, take words literally, so the service provider must be sure to use concrete language herself. For example, if you ask a young child, “Did he drive you away in his car?” the child may answer negatively—if the actual vehicle was a truck.
- » Empower children. After children describe events or occurrences in their lives and talk about their reactions, they must be reassured that they “did the right thing” by telling another person about these events. It may be helpful to allow them the opportunity to explore their ideas and solutions: “What would you tell other kids to do if they were in the same situation?” If they are unable to reply, you can offer them paper and crayons and see if they want to draw their ideas.

3 CORE SKILLS: ENGAGING AND COMMUNICATING WITH CHILD SURVIVORS



Photo: Abigail Erikson/the IRC

CHILD-FRIENDLY NON-VERBAL TECHNIQUES USING ART, DOLLS AND OTHER ACTIVITIES TO COMMUNICATE

Children who have been sexually abused can benefit from non-verbal techniques to facilitate information sharing throughout all stages of the child's care and treatment process. Non-verbal techniques can be used during assessment interviews with child survivors (for example, to help a child share his/her story or clarify specific information) and as part of psychosocial care (by helping children express their feelings through art, play and other activities). Non-verbal methods of communication offer many benefits:

- » Children may feel less threatened using non-verbal methods than sitting in a room talking.
- » Children may find it easier to express emotions through drawings or stories, especially younger children and children not used to expressing emotions or answering questions.
- » Children express emotions, thoughts, ideas and experiences both during and after the non-verbal communication activity.

EXAMPLES OF NON-VERBAL TECHNIQUES

Children of all ages can benefit from a service provider who has several methods for giving and receiving information. Children who are younger and/or not responsive to verbal communications can benefit from the option of communicating through the use of art and other materials. Service providers can apply these materials in two ways: nondirective and directive.

1. **Nondirective techniques** apply when a service provider invites children to draw a picture or tell a story, but does not give specific directions about what they might draw or say. The person working with the child can then see what the child may be thinking or feeling, based on what the child chooses to draw, and so on. This is a good way to engage children at the beginning of an interview or meeting, allowing the child to relax and engage in a fun and creative activity without being told what to do.
2. **Directive techniques** apply when a service provider asks a child to participate in an art or other creative activity. For example, asking a child to draw a picture “of their happiest memory” or to make a picture or visual depiction of “who lives in their house” are examples of directive techniques. These techniques can be very useful during interviews with children to gather information about specific areas of a child’s life. Examples of directive art and play techniques that can be used to better understand a child include:
 - **Having a child draw his or her family (anyone living in their house).** This can be a very effective way to find out who lives with the child. Once the child draws the picture, service providers can ask additional questions about

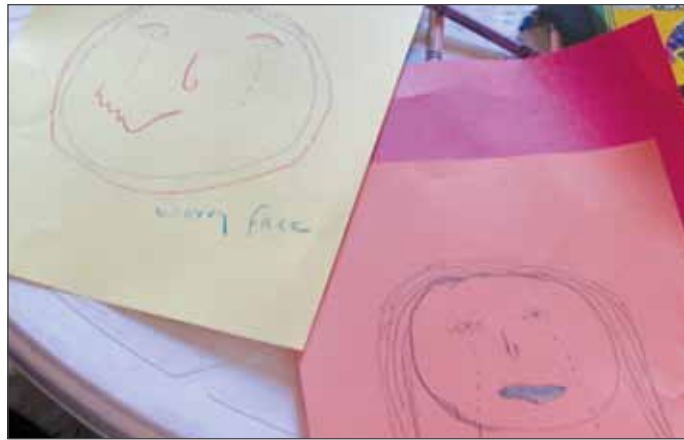


Photo: Abigail Erikson/the IRC

This picture shows drawings made by psychosocial workers to use with their child clients to help the children identify their feelings (sad, worried, happy, etc). Using pictures that show different emotion's can be an effective way to help children express their feelings.

CONSIDERATIONS FOR USING NON-VERBAL TECHNIQUES

All communication techniques, including non-verbal techniques, should be implemented by trained staff and with care and caution. They should be used when:

1. The service provider has been adequately trained in communicating with child survivors and has proper supervision support.
2. It is deemed the child is more comfortable using non-verbal communication techniques.

3 CORE SKILLS: ENGAGING AND COMMUNICATING WITH CHILD SURVIVORS



Photo: Abigail Erikson/the IRC

This picture shows a safety circle drawing. Inside the circle are the things that make this person feel safe and happy. Having children draw their own safety circle (a circle with the people, places and things that make them feel safe and happy inside) is an effective tool for identifying safe people and places in a child's life. This information is essential to incorporate into a child's overall care and treatment planning.

the family: to whom is the child closest? Who is he or she scared of? With whom does he or she get along? What do family members do during the day? ...and so on.

- **Having a child draw his or her daily activities.** This can be an effective way to find out what the child's day is like. Is he or she in school, out of school? Who does he or she spend time with? Does he or she describe certain friends or activities? ...and so on.
- **Having a child draw their safety circle.** The child draws a circle and puts inside the circle what and who makes him or her feel safe. This can be an excellent way to identify safety concerns the child may have. The service provider can take this activity a step further and have the child draw the things outside of the circle that scare them (the circle being the symbolic boundary of safety). This can provide additional information about the child's perception of risk (what and whom) and safety (what and whom).
- **Having a child use dolls.** Using dolls, a child shows where or how he or she was touched.⁴⁸ For example, asking a child to show you where on the doll he or she was touched or hurt. The service provider should not lead the child, for example, pointing to a child's breast, vagina, penis or other body part and asking, "Did he touch you here?" This is a leading question and children may want to please the person asking and could answer "yes" when, in fact, the answer is "no."

⁴⁸ The use of dolls in interviews with children require specific training; caseworkers using dolls should be evaluated on their correct use and understanding prior to using with children.

- **Having a child use dolls to find common language.** It can be very useful to have dolls and drawings to define common terminology for body parts. Studies have shown that children use many different names for private parts⁴⁹, and many young children do not know which parts of the body are considered private.⁵⁰ Young children tend to use a wider range of words to refer to body parts and sexual acts than do older children. Younger children also use the same word or phrases to refer to more than one body part or sexual act. Thus, the service provider must take the time to clarify the words and phrases used by children to ensure an accurate understanding of children's statements.

CASE STUDY: USING A DOLL DURING AN INTERVIEW WITH A SIX-YEAR-OLD BOY SURVIVOR

In a refugee camp, a social worker interviewed a six-year-old boy child about his experiences with sexual abuse. The child had been sexually abused by an older boy, and the child told the social worker that he was hurt in his “bum.” The social worker wanted to make sure that she, and her child client, had the same understanding of the word “bum.” So she brought out her boy doll and she asked the child survivor to show her where the bum was located on the doll. The boy took the doll and pointed to the doll’s rear end. This confirmed for the social worker that she accurately understood what the child survivor was saying.

INTERVIEW GUIDELINES BASED ON AGE AND DEVELOPMENTAL STAGE

Talking with child survivors requires service providers to take into consideration several factors, including the child’s age and stage of development. The level of a child’s development is influenced by many factors besides age. The environment has an important impact, as do education, culture, nutrition, access to health care, social and family interactions, as well as war and violence and their consequences (psychosocial and mental health problems, displacement). Service providers responsible for talking with children about their abuse experience should adapt the length of time according to the child’s age. Age-appropriate lengths of time to talk with children about sexual abuse are:

- » 30 minutes for children under the age of 9;
- » 45 minutes for children between 10–14 years;
- » One hour for children 15–18 years old.

⁴⁹ Cheung, K.F.M., Stevenson, K.M., et al. Competency-based Evaluation of Case Management Skills in Child Sexual Abuse Intervention. Child Welfare League of America, pp. 425-435.

⁵⁰ Ibid.

3 CORE SKILLS: ENGAGING AND COMMUNICATING WITH CHILD SURVIVORS

INFANTS AND TODDLERS (0-5 YEARS OLD)

- » Children in this age range should not be interviewed directly about their abuse. They have limited verbal communication skills and are unlikely to make any disclosures about abuse.
- » The non-offending parents/caregivers should be the primary sources of information about the child and suspected abuse. Other significant adults in the child's life, particularly people who have provided care, should be consulted, including the person accompanying the child.

YOUNGER CHILDREN (6-9 YEARS OLD)

- » Children in this age range can be directly interviewed by the service provider, although we recommend that, if possible, information about the abuse be gathered from trusted sources in the child's life.
- » Children in this age range may have a difficult time answering general questions. This may result in children saying, "I don't remember" or "I don't know" often, or they may give vague responses such as, "The man did a bad thing," but fail to share more.
- » Caregivers/parents or someone the child trusts can be involved in the interview as long as the child requests that the adult be present (and the adult is not a suspected abuser).
- » Children in this age range benefit greatly from a mixture of both verbal and art-based communication techniques.
- » Children in this age range shouldn't be asked questions that involve abstract ideas like justice or love. They tend to think in concrete (literal) terms.

YOUNGER AND OLDER ADOLESCENTS (10-18 YEAR OLDS)

- » Children in this age range can be directly interviewed by the service provider. Open-ended questions can produce important information about sexual assault.⁵¹
- » Caregivers/parents or someone the child trusts can be involved in the interview as long as the child requests that adult to be present (and that adult is not a suspected abuser).
- » Adolescents have more capacity for analytical thought and reflection but service providers should remember they are also still developing.

⁵¹ IASC Training Manual on Caring for Survivors, United Nations International Children's Fund (UNICEF) (2010).

ADDRESSING COMMON COMMUNICATION CHALLENGES

CHILDREN WHO REFUSE TO SPEAK

In some cases, children who are able to communicate verbally may refuse to talk about the sexual abuse they have experienced. Following the communication principles, children who refuse to speak should not be forced to do so. Service providers need to be patient in order to create an environment in which the child feels comfortable enough to disclose information about the abuse. Service providers also need to communicate with the adults that the child trusts in order to determine if there are any urgent medical or safety issues that need to be addressed. In addition, service providers should work with other adults in the child's life to coach them on gathering information that may be helpful in understanding the situation.

Service providers should watch closely for possible reasons as to why the child refuses to speak. It may be that a particular child is just not comfortable with a certain service provider because of his or her sex, age or another factor. Service providers should find another person within their agency to work with the child. Service providers should also consider the following factors:

- » Is there someone in the room who seems to make the child reluctant to speak?
- » Does the child stop speaking when left alone with the service provider, indicating he or she is afraid to talk without another trusted adult present?
- » Are they not speaking because the environment around them is not safe or private, or because they are not ready to trust the service provider? If a child does not want to build trust with a particular service provider, it is not that person's fault. Find other ways to help the child through referrals, talking with family members, etc.

Many other factors may influence why a child refuses to speak about sexual abuse, including fear of consequences (being forced to marry the abuser, for example) and shame. The service provider may want to be proactive in addressing these fears to provide the child survivor with some reassurance that they will be properly helped. If a child never speaks about the abuse, caregivers can often provide adequate information for the child to receive care.

CHILDREN WHO DENY SEXUAL ABUSE

In most child sexual abuse cases, particularly involving younger children, someone other than the child will refer him or her for assistance. There may be times when an adult suspects or has witnessed a child being sexually abused and has disclosed this information to a service provider without the child's permission or knowledge.

In these situations, the role of the service provider is not to determine whether or not abuse has occurred, but to establish a relationship where the child feels safe enough to disclose abuse.

If sexual abuse has been disclosed by a third party, a child may be more likely to initially deny the instance of abuse. Service providers should not attempt to confirm or deny children's initial statements. As we have documented above, children often deny abuse for good reasons—fear of stigma, shame, or retaliation. Sometimes a parent refers an older child or adolescent for services because they are concerned the child is sexually active before marriage. The child however, may not view the sexual activity as abusive and/or may be embarrassed and unwilling to admit to premarital sexual relations.

Service providers will need to gather more information from the caregiver and child separately to gain a better understanding of the situation. They will want to pay special attention to the age and role of the alleged perpetrator. In some situations, there may be age appropriate sexual attraction between teenage girls and boys, which may be upsetting to the parents but is not necessarily an act of sexual abuse.

Service providers will need to use the following strategies in addressing allegations of abuse that the child survivor denies:

- » **Stay neutral:** Do not confirm or deny what the child is saying. Let the child know that you are not there to judge but to listen, understand and help.
- » **Get more facts:** Talk with the child and the person who has referred the child separately. Ask questions that provide a bigger picture of what may be happening: What is the age of the child and the alleged perpetrator? What is their relationship? What is the relationship between the person who reported the case and the child?
- » **Be patient:** Children may not be willing or able to talk about sexual abuse because of the associated shame or stigma. Do not force children to talk about sexual abuse. Service providers need to meet children at their current capacity to share and communicate.

CHILDREN WITH PHYSICAL AND/OR MENTAL DISABILITIES

Children with physical or mental disabilities (for example, deaf and mute) who are suspected or confirmed to have been sexually abused will likely not benefit from verbal interviews. With these child survivors, health and psychosocial service providers will want to use the following strategies:

- » Identify and obtain information from the child's caregiver (a person that the child seems to know and trust).
- » Communicate care and comfort to the child using non-verbal communication techniques (for example, smiling).
- » Use dolls, toys and other art materials to allow the child to communicate freely.
- » Follow the Case Management Guidelines in Chapter 5, which includes guidance for making decisions on behalf of children who are unable to communicate their thoughts and opinions due to disability or some other reason.

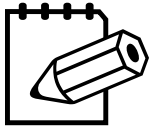
GUIDELINES FOR ASSESSING AND MONITORING CORE COMMUNICA- TION SKILL COMPETENCIES

Health and psychosocial staff responding to cases of child sexual abuse are required to receive training in specialized communication and engagement skills described in this section. A key difference in working with children versus adults is the additional skills needed to effectively communicate. These skills do not come naturally, yet are fundamental to effective care (e.g. case management and psychosocial support) for child survivors.

There are different methods for evaluating staff communication competencies; the following two are recommended:

1. Assessing individual staff members' communication skills using an assessment tool;
2. Directly observing staff providing services to children and giving feedback on examples of good and bad practice during individual and group case supervision.

3 CORE SKILLS: ENGAGING AND COMMUNICATING WITH CHILD SURVIVORS



SUPERVISION TOOL: CCS COMMUNICATION ASSESSMENT (CCS-CA)

The CCS Communication Competency Assessment Tool (CCS-CA) can be used by supervisors to measure an individual staff member's ability to communicate and engage with child survivors as described in this section. This supervision tool can be used in addition to other tools employed by health and psychosocial service providers.⁵² The CCS-CA is a simple supervision tool to implement. It should be used with staff responsible for providing services to child sexual abuse survivors and, if possible, should be administered following a formal training on communicating with child survivors.

USING THE CCS-CA TOOL

STEP 1

Set up an assessment interview session between the supervisor and staff person being evaluated. The assessment interview should take place in a private and quiet space and will take between 30–60 minutes.

⁵² For example, the CCS-KA and the CCS Attitude Scale can be used in conjunction with the CCS-CA Tool. These three tools used together provide a structured method for assessing knowledge, attitude and communicate competencies for working with child survivors. Demonstrating competency in these three areas shows that field staff has the requisite foundational knowledge and skills to provide more advanced services such as health care, case management and psychosocial care.

full tool at end of chapter

Supervision Tool Caring for Child Survivors Communication Assessment (CCS-CA)

Date:
Staff Name:
Supervisor:

Instructions for Administering the Tool

PURPOSE

This assessment represents the minimum communication skills standards for psychosocial and health staff working with child survivors of sexual abuse. Competent care rests on service providers being able to communicate (giving and receive information) with child survivors appropriately. This is a staff supervision tool for managers/supervisors to use periodically with staff providing care directly to children and families.

INTRODUCTIONS

- (1) This supervision tool should be performed through a verbal interview between the staff and his/her supervisor in a quiet and confidential location.
- (2) The supervisor should inform the staff person this tool is being used to assess areas where further capacity building is needed. It is not a performance evaluation tool. The supervisor should explain they will receive a score to determine if individual staff member 'meets' the overall communication competency assessment.
- (3) The supervisor asks the staff person to explain/describe the concepts below and score accordingly:
 - **Met:** If the individual is able to answer the questions correctly and fully, they will receive a mark of 'met'.
 - **Partially Met:** If the individual is able to answer at least 50% of the question, they will receive a mark of partially met.
 - **Unmet:** If the individual is unable to answer the question, they will receive a mark of 'unmet'.
- (4) Once the assessment is complete, the supervisor will score the assessment and discuss with the staff member his/her scores, what they mean, and any further capacity building needed

Administering the Tool

Child Communication & Engagement Skill	Criteria for Answering Correctly	Met 2 pts	Partially Met, 1 pt	Not Met 0 pts
1. Healing statements: child survivors should hear from a service provider throughout care?	Need to list at least 4 statements for full (100%) score, and at least 2 statements must be 'not fault' and 'I believe you': <ol style="list-style-type: none">I believe you.This is not your fault.I am very glad you told me.I am sorry this happened to you.You are very brave for telling me and we will try to help you.Other culturally appropriate healing statement			
2. Describe how you should begin an intake and assessment session with a child.	Need to at least say the importance of starting with general questions and building some trust before asking: <ol style="list-style-type: none">Warm welcomeStart with general questionsAsk the child if h/she knows why they are speaking with youExplain the child's rights (allowed to not answer a question or stop at anytime, etc.)Offer the child a toy or something to hold on to (if there is something)Offer encouraging statements along the way.			
3. Describe how to use your body language (i.e. eye contact, position of your body) to help a child feel safe and comfortable.	Need to explain 4 ways body language would be adapted for full points: <ol style="list-style-type: none">Sit on the floor with a younger childUse appropriate eye contactFriendly expression on faceSoft, gentle voiceOther culturally appropriate thing to do			

STEP 2

Explain to the person being assessed that:

- » The purpose of the assessment is to identify areas of strength and where additional training on child specialized communication skills would be beneficial. The purpose of the assessment is to evaluate specific skills on communicating with child survivors.
- » He/she will not be penalized if he/she does not fully meet the competency assessment. However, he/she will need to demonstrate improved skills over time to avoid other consequences.
- » **Note:** Supervisors should approach these assessment interviews in a friendly, supportive and relaxed manner. This does not mean that the assessment is not taken seriously. Rather, a friendly and supportive approach can help ease the nervousness and fear a person may be feeling.

STEP 3

Implement the CCS-CA Tool

- » The CCS-CA Tool is divided into 14 questions on the essential communication skill areas outlined above.
- » The supervisor verbally asks the individual to explain the specific points being asked. The supervisor can also ask the individual to role play answers during the assessment in order to more easily observe skills in action.

Administering the Tool				
Child Communication & Engagement Skill	Criteria for Answering Correctly		Met 2 pts	Partially Met, 1 pt
1. N healing statements child survivors should hear from a service provider throughout care?	Need to list at least 4 statements for full (100%) score, and at least 2 statements must be 'not fault' and 'I believe you':	1. I believe you. 2. This is not your fault. 3. I am very glad you told me. 4. I am sorry this happened to you. 5. You are very brave for telling me and we will try to help you. 6. Other culturally appropriate healing statement		
2. Describe how you should begin an intake and assessment session with a child.	Need to at least say the importance of starting with general questions and building some trust before asking:	1. Warm welcome 2. Start with general questions 3. Ask the child if h/she knows why they are speaking with you 4. Explain the child's rights (allowed to not answer a question or stop at anytime, etc). 5. Offer the child a toy or something to hold on to (if there is something) 6. Offer encouraging statements along the way.		

**CCS-CA
Answer Sheet**
(first page of tool)

3 CORE SKILLS: ENGAGING AND COMMUNICATING WITH CHILD SURVIVORS

- » The supervisor assesses the accurateness of the answer using the “criteria for answering correctly.” Answers are rated according to three possible levels:
 - **MET:** If the individual demonstrates 100% competency in the communication skill area(s), they will receive a mark of “met.”
 - **PARTIALLY MET:** If the individual demonstrates 50% competency in the communication skill area(s), they will receive a mark of “partially met.”
 - **UNMET:** If the individual is unable to answer or demonstrate competency, they will receive a mark of “unmet.”

STEP 4

Scoring the CCS-CA Tool

- » The supervisor administering the tool will need to add up the points in each column and then total each column for a final score. Only one score is allowed per question.

CCS-CA
Scoring Section
(last page of tool)

TOTAL POINTS QUESTIONS 1-15				
TOTAL SCORE				
Evaluating Communication Skill Competency 20-30 points: MET: Scores in this range indicate that the individual has met the core communication skill requirements and is able to work independently with children and families, with ongoing supervision. 10-18 points: PARTIALLY MET: Scores in this range indicate additional training is needed to build knowledge and skills on child-centered communication. The staff person should be monitored very closely if working on child sexual abuse cases. A capacity building plan should also be put into place. This may include one-on-one mentoring sessions, additional training opportunities, shadowing fellow staff members, among other capacity building activities. 0-8 Points: NOT MET: Scores in this range indicate that the staff person does not yet have the sufficient knowledge and skills to communicate with child survivors. Additional training and support should be provided and the CCS-CA should be re-administered again after further training. A capacity building plan should also be put into place. This may include one-on-one mentoring sessions, additional training opportunities, shadowing fellow staff members, among other capacity building activities.		Final Evaluation: _____ MET _____ PARTIALLY Met _____ UNMET		

- » Understanding the score:
 - **20–30 points: MET** Scores in this range indicate that the individual is able to demonstrate ability in child-centered communication and interviewing skills. The individual is able to work independently with children and families with ongoing supervision.
 - **10–18 points: PARTIALLY MET** Scores in this range indicate additional training is needed to build skills and understanding in communicating with child survivors. The individual should be monitored closely if working on child sexual abuse cases and actively engaging children in case management or psychosocial services.

- **0–8 Points: NOT MET** Scores in this range indicate that the individual does not yet have sufficient skills to communicate with child survivors. Additional training and support should be provided and the CCS-CA tool should be re-administered after further training and skills development.

STEP 5

Review the score with the individual:

- » Review the final assessment score as soon as possible so the staff person need not be anxious about his/her performance. It is recommended the score be communicated to the staff person immediately following the assessment interview.
- » Review the correct and incorrect answers with the individual. Reassure and affirm the staff person on the communication skills he/she demonstrates well. Answer any questions the individual may have; allow him or her to ask questions and share their thoughts and concerns.
- » Develop a plan for additional training and capacity building. This plan can be written into the CCS-CA Tool and the supervisor and staff person may keep a copy. The supervisor should store the CCS-CA results in a locked file in their personal file cabinets to protect the individual's confidentiality. Explain to the staff person where their assessment will be stored; explain their rights to confidentiality and make sure a plan is in place if they did not fully meet the competency.

ONGOING MONITORING

After the initial evaluation, it is recommended that the CCS-CA tool (or another communications competency tool developed locally) be administered to staff every six months. This provides an opportunity to see if the staff member's application of skills is changing over time and to correct any communication skill deficiencies that may have developed since the initial evaluation. In addition, this provides opportunity to service providers to engage in their own self-learning process when working on cases as challenging as sexual abuse toward children.

DIRECT OBSERVATION AND SUPERVISION

In addition to administering the formal CCS-CA Tool to assess technical communication skills, supervisors should identify ways to directly observe staff working with children and families. Direct observation is a more accurate assessment of an individual's competency in working with children and families in a direct response capacity.

CONCLUSION

This chapter outlined the guidance for communicating with child survivors, including verbal and non-verbal communication techniques, and guidelines for structuring interviews. In addition, we introduced the CCS-CA assessment tool to help supervisors assess and monitor competency among individual staff. Effective communication is extremely important for ensuring that:

- » A caring and compassionate relationship develops between the service provider and child and family clients.
- » Service providers communicate important information to children and families in a way they can accept and understand.
- » Service providers obtain crucial information about a child's exposure and experiences with sexual abuse that can be used in direct care and treatment.

Supervision Tool

Caring for Child Survivors Communication Assessment (CCS-CA)

Date:

Staff Name:

Supervisor:

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2. Describe how you should begin an intake and assessment session with a child.	Need to at least say the importance of starting with general questions and building some trust before asking: 1. Warm welcome 2. Start with general questions 3. Ask the child if h/she knows why they are speaking with you 4. Explain the child's rights (allowed to not answer a question or stop at anytime, etc). 5. Offer the child a toy or something to hold on to (if there is something) 6. Offer encouraging statements along the way.			
3. Describe how to use your body language (i.e. eye contact, position of your body) to help a child feel safe and comfortable.	Need to explain 4 ways body language would be adapted for full points: 1. Sit on the floor with a younger child 2. Use appropriate eye contact 3. Friendly expression on face 4. Soft, gentle voice 5. Other culturally appropriate thing to do			

4. Describe how you would explain a health referral to a child survivor between the ages of 10-12	Should include all the following points for full score:	<ol style="list-style-type: none"> 1. Accurate description of health care services (includes risks/consequences) and 2. What the child's rights are during the health care treatment and exam. 			
5. Describe how you would explain a protection referral ages of 10-12	Should include all the following points for full score:	<ol style="list-style-type: none"> 1. Accurate description of the protection services (includes risks/consequences)and 2. Explaining what will happen when the protection staff talk to the child. 3. Explaining what the child and family's rights are during the police interviews 			
6. Explain how to find out how a child is feeling using child friendly materials (drawings, toys, etc)	Correct answers can include any of the following ideas:	<ol style="list-style-type: none"> 1. Draw pictures of faces that represent different feelings and ask the child which one is the closest to how he or she feels. 2. Ask the child to draw a picture about what is the feeling in their mind and heart 3. Ask the child to use colors to represent the different feelings they have 4. Other idea/activity that the social worker has that would be good to try 			
7. What are some important choices you should offer to children before talking with them about their abuse experience?	Need to provide at least 3 choices to get full score:	<ol style="list-style-type: none"> 1. The choice to have a caregiver or trusted person in the room 2. The choice of where to have the conversation 3. The choice to decide when to have the conversation. 4. If possible, the choice to have either a male or female interviewer - this is more specific to boy child survivors. It is always best practice for girls to be interviewed by female counselors as they are almost always abused by men. 			
8. If a child is under the age of 5, who should you talk to find out what happened to the child	Must make the following 2 points for full credit.	<ol style="list-style-type: none"> 1. First, the person who brought the child is 2. The child's caregiver (if appropriate) 			
9. What are some key healing statements to say to a non-offending caregiver/parent who is distressed by their child's sexual abuse	Need to name at least 4 statements for full credit:	<ol style="list-style-type: none"> 1. This is not your fault (if that is true) 2. We can help you and your child get better. 3. This happens to other children too. 4. You are not a bad parent because this happened. Sexual abuse is the fault of the perpetrator. 5. Other statement that is culturally relevant. Problems developing, such as losing ability to talk. 			
10. What is the maximum amount of time you should interview a child about his/her sexual abuse	Correct answer	<ol style="list-style-type: none"> 1. Depends upon the age of the child, between 30 minutes to one hour. 			
11. What is the difference between interviewing a 7 year old and a 17 year old	Need to name at least 2 points for full credit:	<ol style="list-style-type: none"> 1. 17 year old can understand what has happened more 2. 17 year old will have more capacity to offer ideas, opinions about what should happen. 3. 17 year old will be more concerned about social impacts and stigma of abuse. 			
12. If a child refuses to talk to you (and is not disabled or hearing impaired) what are three things you should evaluate as the service provider?	Need to name at least 2 points for full score:	<ol style="list-style-type: none"> 1. Is there somebody in the room the child does not feel safe speaking in front of 2. Are you acting in a way that is making the child uncomfortable 3. Is the interview place safe for the child to speak 			



Chapter Four

GUIDING PRINCIPLES AND KEY ISSUES

This chapter is for health and psychosocial service providers.

CONTENTS OF THIS CHAPTER INCLUDE

- » Overview of guiding principles for working with child survivors
- » Caring for Child Survivors Key Issues
 - **Key Issue 1:** Mandatory Reporting Requirements in Child Cases
 - **Key Issue 2:** Confidentiality Protocols in Child Cases
 - **Key Issue 3:** Ensuring the Best Interest of the Child-Balancing Roles in Decision-Making

CHAPTER OVERVIEW

This chapter introduces a set of guiding principles representing best practice from both the child protection and GBV sectors. These guiding principles provide ethical and practical guidelines for working with child survivors. The chapter then outlines guidance for how to approach key issues and procedures, such as handling mandatory reporting and confidentiality protocols in child abuse cases. It also addresses ways to balance the best interests of the child throughout service delivery by focusing on the roles of the child, caregiver and service provider in the decision-making process.

This chapter serves as precursor to the following chapters, which explain how to provide **case management** and **direct psychosocial care interventions**. Service providers must have a solid understanding of the issues covered in this chapter prior to offering services because they are often required to follow certain practices or laws for handling mandatory reporting, confidentiality, and decision-making in informed consent procedures as part of their overall service delivery guidelines. Specific instructions on how to obtain permission from caregivers and children for participating in case management and referrals for other services (referred to as informed consent and informed assent) are outlined in Chapter 5.

GUIDING PRINCIPLES FOR WORKING WITH CHILD SURVIVORS OF SEXUAL ABUSE

Service providers caring for child survivors should adhere to a common set of principles to guide decision-making and overall quality of care. Guiding principles set out the ethical responsibilities and behaviors of service providers delivering direct services to children and families seeking assistance. They assure service providers that actions taken on behalf of child clients are supported by standards of care that aim to benefit the health and well-being of the child client(s). Guiding principles ensure that all actors are accountable to minimum standards for behavior and action, and because of that, children and families receive the best care possible.

These guiding principles draw upon best practice principles outlined in the UNHCR Guidelines on Sexual Violence Response and Prevention and the United Nations Convention for the Rights of the Child.⁵³ The expectation is that humanitarian staff providing case management, health and psychosocial services to child survivors of sexual abuse adhere to these principles and understand how they are applied in direct practice.

1. Promote the Child's Best Interest

A child's best interest is central to good care. A primary best interest consideration for children is securing their physical and emotional safety—in other words, the child's well-being—throughout their care and treatment. Service providers must evaluate the positive and negative consequences of actions with participation from the child and his/her caregivers (as appropriate). The least harmful course of action is always preferred. All actions should ensure that the children's rights to safety and ongoing development are never compromised.

2. Ensure the Safety of the Child

Ensuring the physical and emotional safety of children is critical during care and treatment. All case actions taken on behalf of a child must safeguard a child's physical and emotional well-being in the short and long terms.

3. Comfort the Child

Children who disclose sexual abuse require comfort, encouragement and support from service providers. This means that service providers are trained in how to handle the disclosure of sexual abuse appropriately. Service providers should believe children who disclose sexual abuse and never blame them in any way for the sexual abuse they have

⁵³ Sexual Violence Against Refugees: Guidelines on Prevention and Response © 1995, United Nations High Commissioner for Refugees, Geneva. Can be downloaded here: <http://www.icva.ch/doc00000837.html>

experienced. A fundamental responsibility of service providers is to make children feel safe and cared for as they receive services.

4. Ensure Appropriate Confidentiality

Information about a child's experience of abuse should be collected, used, shared and stored in a confidential manner. This means ensuring 1) the confidential collection of information during interviews; 2) that sharing information happens in line with local laws and policies and on a need-to-know basis, and only after obtaining permission from the child and/or caregiver; 3) and that case information is stored securely. In some places where service providers are required under local law to report child abuse to the local authorities, mandatory reporting procedures should be communicated to the children and their caregivers at the beginning of service delivery. In situations where a child's health or safety is at risk, limits to confidentiality exist in order to protect the child.

5. Involve the Child in Decision-Making

Children have the right to participate in decisions that have implications in their lives. The level of a child's participation in decision-making should be appropriate to the child's level of maturity and age. Listening to children's ideas and opinions should not interfere with caregivers' rights and responsibilities to express their views on matters affecting their children. While service providers may not always be able to follow the child's wishes (based on best interest considerations), they should always empower and support children and deal with them in a transparent manner with maximum respect. In cases where a child's wishes cannot be prioritized, the reasons should be explained to the child.

6. Treat Every Child Fairly and Equally (Principle of Non-Discrimination and Inclusiveness)

All children should be offered the same high-quality care and treatment, regardless of their race, religion, gender, family situation or the status of their caregivers, cultural background, financial situation, or unique abilities or disabilities, thereby giving them opportunities to reach their maximum potential. No child should be treated unfairly for any reason.

GUIDING PRINCIPLES FOR WORKING WITH CHILD SURVIVORS

1. Promote the Child's Best Interest
2. Ensure the Safety of the Child
3. Comfort the Child
4. Ensure Appropriate Confidentiality
5. Involve the Child in Decision-Making
6. Treat Every Child Fairly and Equally
7. Strengthen Children's Resiliencies

4 GUIDING PRINCIPLES AND KEY ISSUES

7. Strengthen Children's Resiliencies

Each child has unique capacities and strengths and possesses the capacity to heal. It is the responsibility of service providers to identify and build upon the child and family's natural strengths as part of the recovery and healing process. Factors which promote children's resilience should be identified and built upon during service provision. Children who have caring relationships and opportunities for meaningful participation in family and community life, and who see themselves as strong will be more likely to recover and heal from abuse..⁵⁴

APPLYING GUIDING PRINCIPLES IN CASE WORK

Guiding principles are brought to life in everyday case actions. Service providers apply guiding principles in different ways, at different times, and based on the specific child's situation. The primary guiding principle, to ensure the best interest of the child, may mean different things for different children. For example, it is not in the best interest of a 14-year-old girl who has been sexually abused by her father to obtain the father's permission for her to receive care and treatment. Why? Because he is the perpetrator and it is not safe to engage a perpetrator in a child's care and treatment. Therefore, the child may be able to decide herself (guiding principle #5) to undergo psycho-social treatment or health services without her father's knowledge. In this case, whether it is safe (guiding principle #2) to include her mother in treatment will depend upon the child's views and opinions (guiding principle #5) and the potential risks and benefits to the child for including her mother (guiding principle #2). Caseworkers will determine how to handle confidentiality (guiding principle #4), especially concerning whether or not to inform the mother about the child's situation, based on a careful analysis of the factors and in partnership with the child.

Understanding how to use the guiding principles in everyday case work requires practice, supervision and reflection. Applying the guiding principles requires careful analysis of a set of complex factors specific to each child's situation. These principles are meant to guide decision-making; however, they are not a formula for deciding the course of action. Decision-making and good case management practice rests upon the service provider's skill and sensitivity in bringing these principles to life—in a way that continually upholds the child's best interest. Supervisors and managers will need to carefully train staff and supervise how staff apply these principles in day-to-day case work.

⁵⁴ Perry, B. (2007). *The boy who was raised as a dog: And other stories from a child psychiatrist's notebook: What traumatized children can teach us about loss, love, and healing*. New York: Basic Books.



Photo: Gina Bramucci/the IRC

CARING FOR CHILD SURVIVORS KEY ISSUES

This section covers the following key issues in working with child survivors:

Issue 1: understanding mandatory reporting requirements;

Issue 2: confidentiality protocols in child sexual abuse cases; and

Issue 3: ensuring the best interest of the child: balancing roles in decision-making

ISSUE 1: MANDATORY REPORTING REQUIREMENTS

One of the main differences in working with children as opposed to adults is the need for health and psychosocial providers to comply with laws and policies regulating response to the suspected or actual abuse of children. These laws and policies are often referred to as “mandatory reporting laws” and they vary in scope and practice across humanitarian settings. To appropriately comply with mandatory reporting laws, service providers must have a thorough understanding of the mandatory reporting laws in their setting. In settings where laws and systems exist, service providers should have established procedures in place for reporting suspected or actual abuse before providing services directly to children. The elements of mandatory reporting that actors should agree upon to create the safest and most effective reporting mechanisms include first answering the

4 GUIDING PRINCIPLES AND KEY ISSUES

question: Does a mandatory reporting law or policy exist in my setting? If yes, actors should establish procedures based on answering these key questions:

- » Who is required to report cases of child abuse?
- » Who are the officials designated to receive such reports?
- » When is the obligation to report triggered (i.e., with suspicion of abuse?)
- » What information needs to be shared?
- » What are the reporting regulations regarding timing and other procedures?
- » How is confidentiality protected?
- » What are the legal implications of not reporting?

REMEMBER

The best interest of the child should always be the primary consideration when taking actions on behalf of children, even in the context of mandatory reporting laws.

REPORTING CASES OF CHILD SEXUAL ABUSE

If service providers are required to report cases of child sexual abuse to local authorities and reporting systems are established and functioning, then they must follow the local protocol and clearly explain this to the client. Reporting suspected or actual cases of sexual abuse is very sensitive and the report should be handled in the safest and most discrete manner possible. Mandatory reporting in cases of child abuse is not the same thing as referring a child for immediate protection if they are in imminent danger. If a child is in imminent danger, then caseworkers should take actions to secure his/her safety (through referral to local police, protection agencies, etc.) prior to making a mandatory report to the designated mandatory reporting agencies. Once the child is safe, caseworkers should proceed with mandatory reporting procedures. Best practice for reporting cases of child sexual abuse (in settings where mandatory reporting systems function) includes:

- » inclusion of protocols for maintaining the utmost discretion and confidentiality of child survivors,
- » knowing the case criteria that warrant a mandatory report,
- » making the verbal and/or written reports (as indicated by law) within a specified time frame (usually 24 to 48 hours),
- » reporting only the minimum information needed to complete the report,
- » explaining to the child and his/her caregiver what is happening and why, and
- » documenting the report in the child's case file and following up with the family and relevant authorities.

Strategies for reporting abuse while maintaining discretion and the confidentiality of child survivors and their families should be discussed and agreed upon by key actors in the field. Examples on how to best uphold discretion and confidentiality in mandatory reporting circumstances should include: agreeing with other actors on the least amount of information necessary for sharing; reporting to only one mandatory reporting entity/person; and establishing guidelines regulating how third parties store information.

MAINTAINING CHILDREN'S BEST INTERESTS IN MANDATORY REPORTING PROCEDURES

Mandatory reporting requirements can raise ethical and safety concerns in humanitarian settings, where governance structures often break down and laws exist in theory but not in practice. In emergency settings, where established and safe mechanisms to report child sexual abuse might not exist and where security can be unstable and dangerous, mandatory reporting can set off a chain of events that potentially exposes the child to further risk of harm, and as such it may not be in the child's best interest to initiate a mandatory report. For example, investigators may show up to a child's home, therefore, potentially breaching a child's confidentiality at the family or community level (prompting retaliation). In addition, services for children may be non-existent, thus creating additional risk (e.g., separation from family, placement in institutions, or confiscation of private records). The local authorities may themselves be abusive or they may simply be ignorant of best practice procedures or guiding principles.

If these following criteria are present, even if a mandatory law exists in theory, service providers are advised to use the central guiding principle—the best interests of the child—to guide decision-making in child-centered service delivery:

- » Authorities lack clear procedures and guidelines for mandatory reporting.
- » The setting lacks effective protection and legal services to deal properly with a report.
- » Reporting could further jeopardize a child's safety at home or within his/her community.

If these criteria are present, service providers should follow a decision-making process that first considers the child's safety and then the legal implications of not reporting. Supervisors should always be consulted in decision-making to determine the best course of action.

4 GUIDING PRINCIPLES AND KEY ISSUES

Service providers are advised to follow these steps for determining the best course of action:

STEP 1

Use these questions to guide decision-making:

- a. Will reporting increase risk of harm for the child?
- b. What are the positive and negative impacts of reporting?
- c. What are the legal implications of not reporting?

STEP 2

Consult with the program case management supervisor and/or manager to make a decision and develop an action plan.

STEP 3

Document with a supervisor or manager the reasons to report the case; otherwise, document the safety and protection issues that rule out making a report.

EXPLAINING MANDATORY REPORTING AT THE VERY BEGINNING OF CARE AND TREATMENT

If mandatory reporting policies and laws are in place and practiced, service providers are required to explain to the child and caregiver what their reporting responsibilities are at the beginning of services. This can be done in conjunction with the initial informed consent procedure for the services being offered (see Chapter 5 for more information on informed consent procedures).

If a mandatory report is required, service providers should share the following information with children and caregivers:

- » The agency/person to which/whom the caseworker will report.
- » The specific information being reported.
- » How the information must be reported (written, verbal, etc.).
- » The likely outcome of the report.
- » The child's and family's rights in the process.

- » Children, particularly older children (adolescents), and caregivers should be part of the decision-making process on how to address mandatory reporting in the safest and most confidential way. This means service providers should seek and consider their opinions and ideas on how to draft the report. This does not mean the caregiver and child can decide whether or not a report is made; rather, they can help decide how and when the report is made. Service providers who are equipped with in-depth knowledge about mandatory reporting procedures will be best positioned to work with children and family clients to manage this procedure as necessary.

SUMMARY OF KEY COMPETENCIES FOR MANDATORY REPORTING

Service providers must be able to:

- » Demonstrate an accurate understanding of the mandatory reporting laws/policies in their context.
- » Analyze specific criteria to determine whether reporting is in the child's best interest, and document and report this information to supervisors and/or the child's case response team.
- » Explain mandatory reporting requirements to children and caregivers at the outset of service delivery.
- » **Remember:** The most beneficial/least detrimental course of action for the child, and the least intrusive one for the family, should be employed as long as the child's safety is assured.

ISSUE 2: CONFIDENTIALITY PROTOCOLS IN CHILD CASES

Confidentiality is an ethical principle closely associated with medical and social service professions. Confidentiality is also one of the guiding principles in GBV, health and child protection case response, and caseworkers are expected to uphold client confidentiality as a matter of best practice. Maintaining confidentiality requires that service providers collect information in safe ways, protect all information gathered about survivors and agree to share only after gaining explicit permission (also called informed consent and/or informed assent) of the child client and his/her caregiver.

4 GUIDING PRINCIPLES AND KEY ISSUES

Confidentiality protocols and decisions are more straightforward when working with adult survivors. For example, decisions about who to share information with is almost always made by the adult survivor and caseworkers are bound to respect these decisions.⁵⁵ However, working with children, especially younger children, requires understanding the legal limits to confidentiality. Caseworkers must be upfront and clear with children and caregivers concerning the limits to confidentiality.

The following situations may require service providers to share information with third person(s):

- » the existence of mandatory reporting laws and policies;
- » the need to protect a child's physical and/or emotional safety or to provide immediate assistance. This is applicable if the child is:
 - at risk of hurting or killing himself (suicidal).
 - at risk of being hurt or killed by someone else.
 - at risk of hurting or killing another person (homicidal).
 - injured and in need of immediate medical attention.
- » the need to inform a child's parent/caregiver in order to obtain permission to provide care and treatment to the child as long as there are no dangers in doing so. For example, if a 10-year-old child, with supportive caregivers at home, independently requests social and/or health services, parental permission would be sought to treat the child.

Service providers should have a standard set of agency-specific confidentiality protocols that guide all staff providing care to children. This will help service providers explain such protocols in a clear and consistent manner to child clients prior to commencing services. Discussions about how best to protect the confidentiality of the child and his/her access to support services are an ongoing element of the case management process. In the context of case referrals as presented in Chapter 5, service providers discuss with their clients which information they would choose to share with other service providers. If a child needs protection—for example, he/she is being stalked and at risk of imminent harm—it may be necessary to provide information to local law enforcement in order to protect the child. This does not mean that all, but only some, information about a child's case needs to be shared in order to provide a service or protect a child's safety. How much and what to share should always be discussed and decided with both the child and the caregiver.

⁵⁵ Unless the adult survivor is at risk of suicide or is at risk for harming/killing someone else.

EXPLAINING LIMITS TO CONFIDENTIALITY

Service providers can explain to children the limits of confidentiality in a way that respects their dignity. To do so means service providers have the language skills to communicate with children of different ages and respect the fundamental truth that children's experiences and stories belong to them. This means that service providers respect children's stories and experiences by including them in decision-making about how, what and with whom to share information with, in line with existing protocols. Limits to confidentiality are most often communicated during **informed consent procedures**. Below are sample scripts for explaining confidentiality to children of different ages:

SAMPLE SCRIPT: EXPLAINING CONFIDENTIALITY TO AN 8-YEAR-OLD SURVIVOR



"My job is to talk to children and help them with problems they face. I care about you and what happened to you, and I want to keep you safe. What you tell me is between you and me only, unless there is something that you tell me that worries me or if you need help that I cannot give you. If I am worried about your safety, I may need to talk to someone who can help you. If we need to get you more help in order to check your body or talk to someone who can help keep you safe, we will talk together about that other person, and decide what we should say. My job is to try and make sure that you are not hurt anymore, so we may need to also get help from other people in order to keep you safe and healthy. Does this sound okay with you?"

SAMPLE SCRIPT: EXPLAINING CONFIDENTIALITY TO A 12-YEAR-OLD SURVIVOR



"My job is to talk to children and help them with problems they face. Although most of what we talk about is between you and me, there may be some problems you might tell me about that we would have to talk about with other people. For example, if I can't help with you a problem you have, we will need to talk to other people who can help you. Or if I find out that you are in very serious danger, I would have to tell [insert appropriate agency here] about it. If you tell me you have made plans to seriously hurt yourself, I would have to inform your parents or another trusted adult. If you tell me you have made a plan to seriously hurt someone else, I would have to report that. I would not be able to keep these problems just between you and me because I want to be sure that you are safe and protected. Do you understand that it's okay to talk about anything with me, but these are other things we must talk about with other people?"

4 GUIDING PRINCIPLES AND KEY ISSUES

ENSURING THE CHILD UNDERSTANDS

After explaining confidentiality to children, it is important for caseworkers to ask the child a few questions to make sure he/she understands what has been said. Questions such as “Can you tell me what I should do if I thought that someone was hurting you?” or “Can you tell me what my job is?” will help clarify the child’s comprehension.

ISSUE 3: ENSURING THE BEST INTEREST OF THE CHILD: BALANCING ROLES IN DECISION-MAKING

Ensuring that actions taken on behalf of child survivors are in their best interest is the foundation of any service. As outlined in the guiding principles above, determining which courses of action are in the best interest of a particular child requires determining factors such as: 1) a careful evaluation of the child’s situation; 2) meaningful discussion with the child and caregivers about what they believe is in the child’s best interest; and 3) seeking the least harmful course of action. In addition, applying the guiding principle of best interest requires a general understanding of the child’s and caregivers’ roles and rights in the decision-making processes, particularly in situations when caregivers’ decisions do not reflect a child’s best interest. At times, service providers may need to help make informed decisions on behalf of a child as part of their responsibility to protect the child. As with all social service and health care related work, service providers are constantly seeking to understand their client’s context and perspectives; they strive to find a path forward that is in harmony with protecting and promoting the child’s health and well-being.

Service providers have the responsibility to uphold children’s best interests throughout case management, which includes promoting actions that are in their best interest and advocating with other service providers. In case management, there are specific case action criteria for most effectively promoting children’s health and well-being. **Case actions which promote children’s best interests are actions that:**

- » Protect the child from potential or further emotional, psychological and/or physical harm.
- » Reflect the child’s wants and needs.
- » Empower children and families.
- » Examine and balance benefits and potentially harmful consequences.
- » Promote recovery and healing.



Photo: UNICEF/Marta Ramoneda/Haiti

THE CAREGIVER'S ROLE IN CARE AND TREATMENT DECISIONS

The best interests of the child are usually best secured by the parents or caregivers, and involving caregivers in a child's care and treatment is essential. Legally, parents and legal guardians (e.g. caregivers) have the right to make decisions about their child's treatment until the child reaches adulthood and/or the legal age of consent (which varies from country to country). In many humanitarian aid settings such as refugee camps or disaster areas where the rule of law is not fully respected, caseworkers can involve non-offending caregivers in decision-making for children 17 and under, unless it is against the child's best interest.

NEGLIGENT OR ABSENT CAREGIVERS

There may be situations when the caregiver/parent is absent, unwilling or unable to exercise basic parental responsibilities. A caregiver's actions might compromise the child's well-being if:

- » There is suspicion that the parent or guardian is involved in the abuse.
- » The child might become a victim of harmful reactions such as physical punishment or being forced to leave the home.

4 GUIDING PRINCIPLES AND KEY ISSUES

- » The child does not want his/her parents to know about the abuse (and the child is old enough/mentally sound to make such a complex decision).
- » A child is unaccompanied or separated and there is no responsible adult acting as guardian.

In situations when the caregiver has different opinions than those of the child client and service provider regarding the child's best interest, the caseworker discusses the matter with the caregiver and ideally, they together reach an agreement that best supports the child. If the caseworker and caregiver are unable to come to an agreement and it is the caseworker's opinion that the caregiver is not acting in support of the child's best interest, the service providing organization may need to intervene (for example, if a parent refuses to grant permission for life-saving measures or post-sexual abuse medical care). It is essential that the caseworker first consult with his/her supervisors before intervening against the parents' wishes.

Caseworkers should take the following actions if the wishes of a parent/caregiver do not reflect the best interest of the child, particularly with regard to immediate health and safety needs:

STEP 1

Provide the non-offending family members with information, either personally or through a supervisor or other trusted adult, in an effort to engage them with the best possible action plan or treatment. Generally, once concerned parents and caregivers are informed as to why a certain intervention is needed to secure their child's health and well-being, they will most often provide their permission to proceed and take part in the healing process.

STEP 2

In consultation with supervisors, discuss with the child and the child's caregiver/family members the following (if such discussion does not put the child in more danger):

- » The reason for making a particular decision (for example, the decision to seek medical treatment or secure safe housing for the child).
- » That the decision is temporary (provide a timeline for reevaluation of the decision and explain/discuss the next steps for reevaluation).
- » Any arrangements provided for the child/caregiver if, for example, the child has been placed in a safe location away from his/her parents and/or family members. Note: if a caseworker is concerned for the child's safety at home, every effort should be made to secure safer, short-term shelter/housing arrangements.

STEP 3

Follow through with agreed action steps.

THE CHILD'S ROLE IN DECISION-MAKING

In addition to safeguarding children's best interests, guiding principles also aim to encourage service providers to listen to children's thoughts, ideas and opinions affecting their care and treatment. Providing children with information about what is happening, and offering them a chance to express their thoughts, helps them feel safe during their care and treatment. Children's rights in decision-making are based on local laws and service provider policies.

HELPFUL TIP

Service providers should be very clear about their role in decision-making for children seeking services. The role of the service provider is not to make decisions they think are right for the children, but rather to support children in understanding their options and to create a safe space for children to express what they would like to see happen. Service providers must be aware of their personal beliefs and attitudes when it comes to working with all clients, especially children, and are responsible for not imparting their personal beliefs to determine what children should or should not do.



Service providers need to know the following information in regard to children's legal rights in decision-making:

- » The person(s) responsible for providing permission (informed consent) for care and treatment of a child in the local context.
- » The age at which a child is able to independently consent to care and treatment in the local context.
- » The mechanisms for third-party individuals to provide consent if caregivers or parents are not available, or if a caregiver or parent is the suspected perpetrator.

4 GUIDING PRINCIPLES AND KEY ISSUES

Children's abilities to form and express their opinions develop with age, and most adults naturally regard teenagers as more mature and knowledgeable than preschoolers. In some situations, adolescents who are seeking psychosocial and health services may have very good reasons for not wanting their caregivers to know what happened and why they are seeking care. This is particularly true in sexual abuse cases involving family members and/or close family friends. Nevertheless, service providers should aim to help identify a safe and trusted adult in the child's life who can be involved in care and treatment decisions. Otherwise, service providers can benefit by understanding the age and developmental stages of children and how they affect children's rights to participate in decision-making. For example:

- » Children 15 years and up are generally mature enough to make their own decisions.
- » Children 13 to 14 years are presumed to be mature enough to make a major contribution to decisions affecting their care and treatment.
- » Children 10 to 12 years can meaningfully participate in the decision-making process, but maturity must be assessed on an individual basis.
- » Children 9 years and younger have the right to give their opinion and be heard. They may be able to participate in the decision-making process to a certain degree, but caution is advised to avoid burdening them with decisions beyond their ability to understand.

Service providers are responsible for understanding and assessing a child's age and development, and based on this information, providing children with sufficient information to make informed choices. In addition, children should be given the opportunity to express their opinions. That being said, children may not always have their wishes and desires met; in such cases, children have the right to be informed as to why their wishes cannot be accommodated.

CONCLUSION

This chapter covered key issues that arise while working with child survivors. For instance, service providers need to understand the laws and policies in their practice settings as well as protocol regarding confidentiality prior to working directly with children. Working with children requires a solid understanding of the local laws and systems as well as good judgment and an emphasis on promoting safety and security. Working with children is complex; agencies offering case management and psychosocial services must have established supervision systems and staff training programs in place prior to need. Chapter 5 continues with instructions to provide case management services for child survivors and brings to life several of the issues discussed in this chapter.



Chapter Five

CASE MANAGEMENT FOR CHILD SURVIVORS

This chapter is for service providers who offer case management services.

CONTENTS OF THIS CHAPTER INCLUDE

- » Overview of case management
- » Step-by-step guide of case management for child survivors

TOOLS IN THIS CHAPTER INCLUDE

- » Case Management Forms
 - Child Needs Assessment and Action Planning Form
 - Child Case Follow-Up Form
 - Child Case Closure Form
- » Staff Supervision Tools
 - Child Client Satisfaction Questionnaire
 - Case Management Skills Assessment Tool (CCS-CMA)
 - Case Management Checklist Tool

CHAPTER OVERVIEW

This chapter is for service providers that offer case management to children and/or GBV survivors. This chapter builds upon the knowledge, attitude and communication skill competencies outlined in Chapters 1 through 3. The foundational skill set outlined in these previous chapters helps to prepare service providers for conducting child-centered case management.

This chapter builds on the instructions for engaging children and caregivers in care and treatment decisions, including how to obtain permission (i.e. informed consent/informed assent) and the limitations of confidentiality, outlined in Chapter 4. This chapter provides instruction for the step-by-step practice of case management to meet the needs of child survivors of sexual abuse. Readers will learn how to assess children's immediate needs related to their incident(s) of violence, develop immediate care and treatment goals, and implement and monitor child clients' care-action plans. The chapter also provides a checklist for closing a case and offers case management tips and template case management forms.

5 CASE MANAGEMENT FOR CHILD SURVIVORS



HELPFUL TIP

This chapter outlines how to provide **case management services for child survivors**.

Establishing and providing competent case management services in humanitarian aid settings requires specific knowledge and skills. Case management for child survivors of sexual abuse is designed to meet children's health, safety, legal and psychosocial needs. More advanced (and direct) psychosocial interventions for child survivors are expanded upon in Chapter 6. Providing a combination of case management and targeted psychosocial interventions is a more robust level of service delivery. Service providers already conducting case management and who are ready to integrate an additional layer of psychosocial support into case management should follow the guidelines in Chapters 4 through 6.

INTRODUCTION TO CASE MANAGEMENT

Case management, as a practice, gained momentum in the United States in the 1960s and '70s when mental health services were deinstitutionalized and there was a growing need for community-based care.⁵⁶ Later, practitioners realized that case management would be necessary in refugee settings where children and families find themselves in an unfamiliar environment, are experiencing particular problems (such as gender-based violence), and may not be aware of the existing services or how to access them.⁵⁷

Exact definitions of case management vary slightly across the humanitarian aid field.⁵⁸ The definition of social work case management, which is the primary model adapted by the GBV sector in humanitarian aid contexts and used by the U.S. based National Association of Social Workers, is as follows:

"Social work-based case management is a method of providing services whereby a professional social worker assesses the needs of the client and the client's family, when appropriate, and arranges, coordinates, monitors, evaluates and advocates for a package of multiple services to meet the specific client's complex needs."⁵⁹

⁵⁶ IRC Child Protection and Youth DRAFT Development Case Management Guidance Notes, 2011

⁵⁷ IRC Child Protection and Youth DRAFT Development Case Management Guidance Notes, 2011

⁵⁸ Minimum Standards for Child Protection in Humanitarian Response (draft, 2011) defines case management as "the process of assisting individual children and families through the coordination of service provision and management of information by designated caseworkers."

⁵⁹ National Association of Social Workers, http://www.socialworkers.org/practice/standards/sw_case_mgmt.asp#def.

Case management for child survivors requires caseworkers to have specialized knowledge and skills for working with children. Specifically, caseworkers should have the ability to:

- » Apply technical understanding of sexual abuse to educate and support children and families throughout the case management process (Chapter 1 addresses this).
- » Apply appropriate child-friendly attitudes through care and treatment (Chapter 2 addresses this).
- » Apply appropriate communication techniques to engage with children of all levels (Chapter 3 addresses this).
- » Adapt case management steps and procedures for child survivors. This includes:
 - Upholding the guiding principles for working with child survivors.
 - Following informed consent/assent procedures according to local laws and the age and developmental stage of the child.
 - Applying confidentiality protocols to reflect the limits of confidentiality, as in circumstances where a child is in danger.
 - Assessing a child survivor's immediate health, safety, psychosocial and legal/justice needs and using crisis intervention to mobilize early intervention services that ensure the child's health and safety.
 - Conducting ongoing child safety assessments in the family and social contexts after disclosure of abuse. Taking decisive and appropriate action when a child needs protection.
 - Identifying strengths and needs to engage the child and family in a strength-based care and treatment process.
 - Proactively engaging any non-offending caregivers throughout case management.
 - Knowing the child-friendly service providers in the local area and initiating referrals properly.
 - Being able to function independently and collaborate with other service providers.

ROLE OF THE CASEWORKER

The primary role of the caseworker is to 1) support and advocate on behalf of the child and family, 2) be the child's and family's main point of contact for assessment of needs, 3) support care and treatment goals and plan interventions to meet needs, and 4) provide, coordinate and follow up on the provision of services. In some settings, certain agencies are designated as lead case management agencies, which also requires caseworkers to take on the additional responsibility of handling mandatory reporting requirements and organizing case conferencing meetings, among other tasks.

5 CASE MANAGEMENT FOR CHILD SURVIVORS



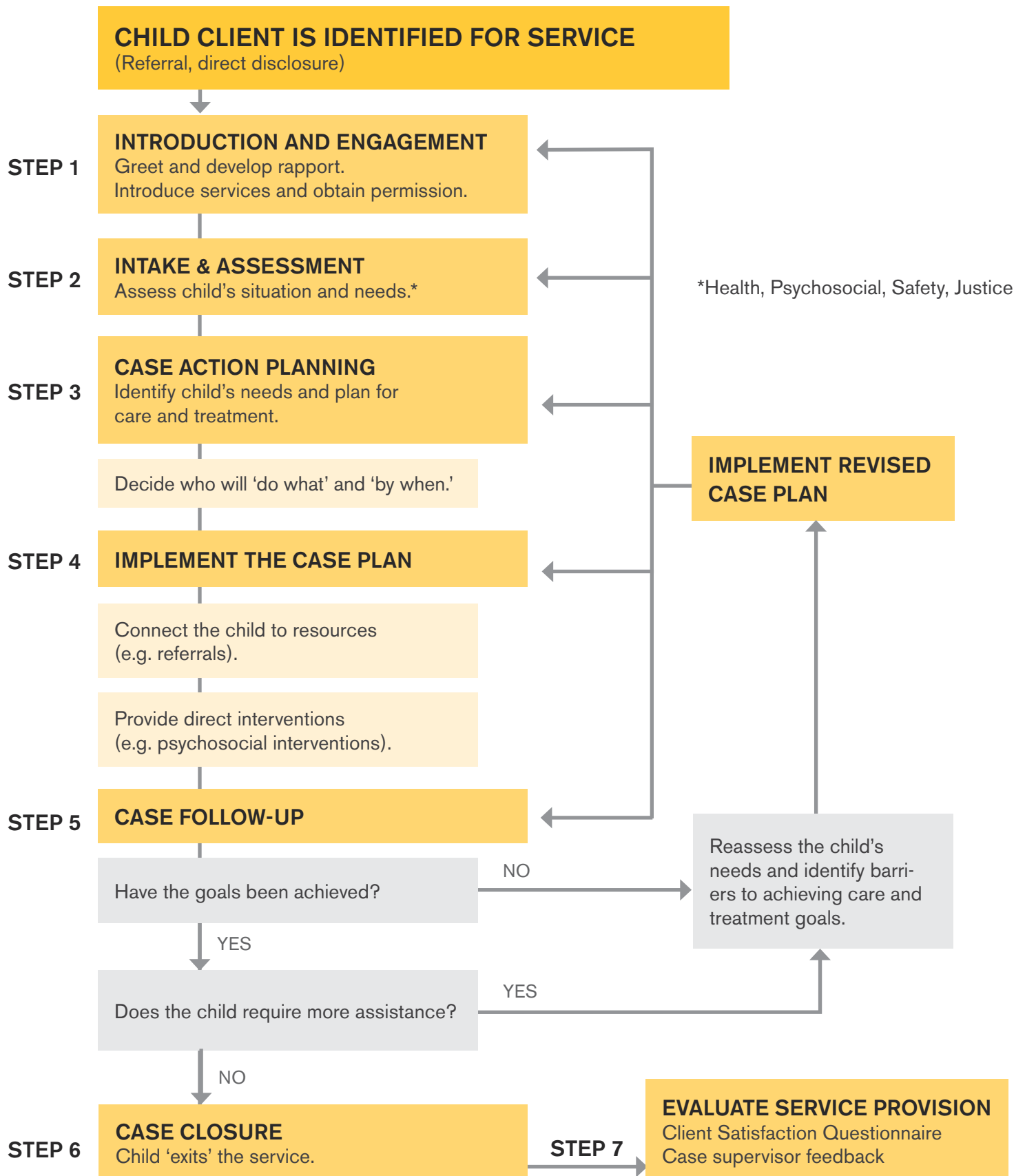
Photo: Gina Bramucci/the IRC

Effective case management can go a long way in supporting a child's journey to recovery and healing from sexual abuse.

STANDARD STEPS OF CASE MANAGEMENT

Case management for child survivors of sexual abuse is focused primarily on meeting the child survivor's health, safety, psychosocial and legal needs following the incident(s). Caseworkers follow standard case management steps used with adult survivors of GBV; however, the steps are adapted to meet children's needs. This chapter outlines the steps of case management and provides detailed guidance for implementing case management for child survivors, including sample child-centered case management forms. A flowchart for the steps of case management is on the next page.

CARING FOR CHILD SURVIVORS OF SEXUAL ABUSE GUIDELINES



5 CASE MANAGEMENT FOR CHILD SURVIVORS

CASE MANAGEMENT TOOLS

To help agencies providing case management services, several case management tools have been developed to accompany the instructions in this chapter. The tools included in this chapter are simply a guide for agencies in the field—these tools can be adapted to meet the needs of your setting and the requirements of your specific agency. An explanation of the tools in this chapter are as follows:

CASE MANAGEMENT STEP	CASE MANAGEMENT TOOLS
STEP 1: INTRODUCTION AND ENGAGEMENT	Sample Informed Consent/Confidentiality Statement
STEP 2: INTAKE AND ASSESSMENT	Child Needs Assessment and Case Action Plan Form The Child Needs Assessment and Case Action Plan form is meant to document the assessment summary outlining the child's main needs and the required actions needed. This form is meant to accompany a standard intake and assessment form used by case management service providers in the field. ⁶⁰
STEP 3: CASE ACTION PLANNING	Child Needs Assessment and Case Action Plan Form This form is used in conjunction with the intake and assessment step. This form includes a section to document each care and treatment needed and planned action (e.g., referral and/or safety plan).
STEP 4: IMPLEMENTATION OF THE ACTION PLAN	No specific tool provided
STEP 5: CASE FOLLOW-UP	Child Case Follow-Up Form This form is used during follow-up visits with the child/caregiver to assess progress made toward care and treatment goals; it is also used to re-assess the child's safety and other actions required to help the child.
STEP 6: CASE CLOSURE	Child Case Closure Form This form is used to formerly document the reasons why the case has been closed, and reviews a checklist of actions to take prior to closing the case. Case closure should always be discussed with the case supervisor, and the case supervisor's signature should be documented on the case closure form.

⁶⁰In the GBV and child protection sectors, standardized tools and systems have been developed to support caseworkers delivering services to children and/or survivors of gender-based violence. An example of the Gender-Based Violence Information Management System (GBVIMS) Initial Intake and Assessment Form is included at the end of this document. For more information about the GBVIMS, please go to www.gbvims.org. For more information about the Child Protection Information Management System (CPIMS) please go to <http://childprotectionims.org>.

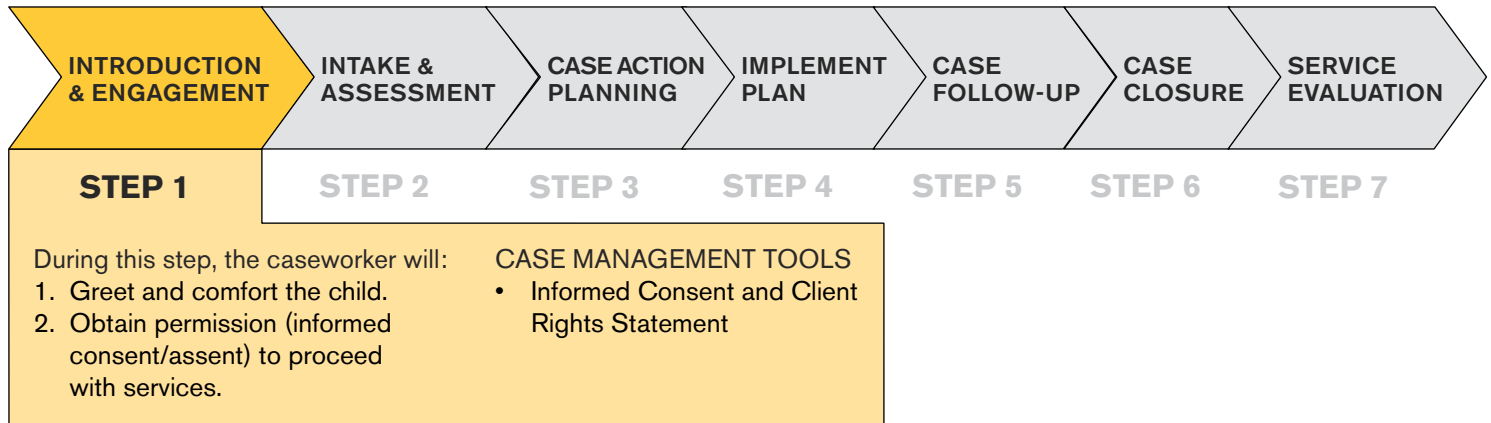
CASE MANAGEMENT STEP	CASE MANAGEMENT TOOLS
STEP 7: SERVICE EVALUATION	<p>Child Client Satisfaction Questionnaire This is an optional tool which can be used in settings that are more stable (e.g., protracted refugee camp contexts and post-conflict settings). Following guidelines, this tool is provided to children and caregivers in order to evaluate their satisfaction with services received from case management and other service providers.</p> <p>CCS Case Management Skills Assessment Tool (CCS-CMA) This tool is used to assess the knowledge and skills of individual caseworkers. It should be used following training on how to provide case management for child survivors to ensure the individual possesses adequate knowledge/skills to work independently with child survivors. This is a capacity-building tool.</p> <p>CCS Case Management Checklist Supervisors use this tool in conjunction with caseworkers to review their performance in child sexual abuse case management. The checklist is used to reflect with the caseworker the successes and challenges of providing case services to individual child clients. This is a capacity-building tool.</p>

STAFF ROLES IN CASE MANAGEMENT SERVICES

Caseworker's Role: The primary duties of the caseworker are to 1) establish rapport and develop a trusting relationship that helps the child and family, 2) support and advocate on behalf of the child and family, 3) act as the child's and family's point of contact for assessment of needs, 4) develop goals and planning interventions, and 5) provide, coordinate and follow up on the provision of services. Caseworkers may also be required to handle mandatory reporting requirements, organize case conferencing meetings, and conduct other tasks required in the case management process.

Case Supervisor's Role: The primary role of the case supervisor is to provide support, advice, direction, and overall quality oversight to the caseworker. The case supervisor is responsible for ensuring the staff is trained and prepared for their case management role and responsibilities, and able to provide best practice services. Case supervisors are on-hand for consultation in emergency situations and provide regular case supervision to caseworkers. They work closely with other senior staff to oversee quality of service for children and families affected by sexual abuse.

STEP 1: INITIAL INTRODUCTION AND ENGAGEMENT IN SERVICES



1. GREET AND COMFORT THE CHILD

The initial case management step of introduction and engagement starts when the caseworker first meets with the child survivor and/or the child's caregiver. This is the caseworker's first chance to develop rapport with a child and his/her caregiver and begin to develop the basis for a trusting relationship. The ability to develop trust and rapport with children and families is largely dependent upon the caseworker's knowledge, attitude, and communication skill competencies, as outlined in the first three chapters of these guidelines.

During the initial meeting with children and their caregivers, caseworkers begin to assess the child's maturity, age and development as well as the caregiver's support to the child. Direct observation of the child and the caregiver helps the caseworker make initial decisions about how to explain services based on the child's age and caregiver situation, and think through who is best-placed to provide permission for starting case management services. In situations when the child is with a caregiver, caseworkers begin by assessing whether or not it is appropriate and safe for the child to speak with the caseworker in the presence of his/her caregiver. For example, if the caseworker suspects the caregiver is dangerous to the child, the caseworker may decide to speak to the child alone rather than with the caregiver, as part of the procedure in obtaining permission to proceed with case management services.

2. OBTAIN PERMISSION TO PROCEED “INFORMED CONSENT AND ASSENT”

At the very outset of meeting with child clients and their caregivers, caseworkers are responsible for engaging clients in services by explaining their individual role and the service(s) available to help the child and family. Most often, children and possibly caregivers will not fully understand the caseworker's role and what is going to happen. As a result, children and caregivers may be fearful or unsure about engaging in services. An important aspect of case management, therefore, is being upfront about the services being offered—and the regulations governing such services (e.g., confidentiality protocols)—and obtaining permission from caregivers and child clients to proceed. Children and caregivers can only agree to participate when they have a full understanding of the services and related benefits and risks. In case management, there are typically three areas where client permission—referred to as “informed consent” and/or “informed assent” (definitions on the next page)—is needed. They are:

- » At the start of case management services: that is, before conducting the initial intake and assessment interview.
- » As part of case management: children and caregivers need to provide their permission for the caseworker to collect and store information about their case throughout the case management process.⁶¹
- » During case referrals: when caseworkers share information with other service providers who can help the child and family meet their specific needs. Often, caseworkers need to seek permission multiple times during case management as new referrals are needed.

In order for children and caregivers to provide their permission to participate in case management, caseworkers need to explain:

- » the caseworker's role and responsibilities in case management.
- » what case management includes (e.g., listening to problems, identifying needs, helping to meet needs) as well as clarify the benefits and limitations of services.
- » what confidentiality means, and how, on occasion, confidentiality cannot be kept (including conditions for which mandatory reporting is required).
- » how client information will be safely and securely stored (this includes any case forms and database systems being used).

⁶¹ Permission to collect and store information about a client also includes obtaining permission to gather and share anonymous incident data for the purposes of gathering statistics on the types and extent of violence happening in the context the service provider is working in. For more information on the guidelines for obtaining permission to collect anonymous incident data, please go to <http://gbvims.org/learn-more/gbvims-tools/intake-form/>.

5 CASE MANAGEMENT FOR CHILD SURVIVORS

- » ways in which the client information will be used (data collection, information sharing for case management).
- » **Caseworkers should always offer children and caregivers the opportunity to ask questions or share concerns during this discussion.**

HOW TO OBTAIN PERMISSION FROM CHILDREN AND CAREGIVERS

Explaining case management services, including the need to collect, store and possibly share their information, and obtaining permission to proceed does not need to be complicated. However, caseworkers are required to know how to obtain permission based on local laws, the child's age and maturity level, and the presence of non-offending caregivers.

As a general principle, permission to proceed with case management (and other case actions) is sought from the child as well as the parent or caregiver, unless it is deemed inappropriate to involve the child's caregiver. Permission to proceed with case management and other care and treatment actions (e.g., referrals) is sought by obtaining "informed consent" from caregivers or older children and/or "informed assent" from younger children. Informed consent and informed assent are similar, but not exactly the same.

- » **"Informed consent" is the voluntary agreement of an individual who has the legal capacity to give consent.** To provide "informed consent" the individual must have the capacity and maturity to know about and understand the services being offered and be legally able to give their consent. Parents are typically responsible for giving consent for their child to receive services until the child reaches 18 years of age. In some settings, older adolescents are also legally able to provide consent in lieu of, or in addition to, their parents.
- » **"Informed assent" is the expressed willingness to participate in services.** For younger children who are by definition too young to give informed consent, but old enough to understand and agree to participate in services, the child's "informed assent" is sought.

GUIDELINES FOR OBTAINING INFORMED CONSENT/INFORMED ASSENT FROM CHILDREN AND CAREGIVERS

The age at which parental consent is needed for a child depends on the laws of the country. This means that when the child is under the age of legal consent, caregiver consent is required. In the absence of any clear laws or adherence to laws, children under the age of 15 require caregiver consent as a general rule.

INFANTS AND TODDLERS (AGES 0–5)

Informed consent for children in this age range should be sought from the child's caregiver or another trusted adult in the child's life, not from the child. If no such person is present, the service provider (case worker, child protection worker, health worker, etc.) may need to provide consent for the child, in support of actions that support their health and well-being.

Very young children are not sufficiently capable of making decisions about care and treatment. For children in this age range, informed assent will not be sought. The service provider should still seek to explain to the child all that is happening, in very basic and appropriate ways.

YOUNGER CHILDREN (AGES 6–11)

Typically, children in this age range are neither legally able nor sufficiently mature enough to provide their informed consent for participating in services. However, they are able to provide their informed assent or "willingness" to participate. Children in this age range should be asked their permission to proceed with services and actions which affect them directly. This permission can be provided orally by the child, and documented as such on the informed consent form. For children in this age range, written parental/caregiver informed consent is required, along with the child's informed assent. If it is not possible to obtain informed consent from a parent or caregiver, then another trusted adult, identified by the child, who can be safely brought into care and treatment decisions should be approached to consent for the child.

YOUNGER ADOLESCENTS (AGES 12–14)

Children in this age range have evolving capacities and more advanced cognitive development, and, therefore, may be mature enough to make decisions on and provide informed assent and/or consent for continuing with services. In standard practice, the caseworker should seek the child's written informed assent to participate in services, as well as the parent/caregiver's written informed consent. However, if it is deemed unsafe and/or not in the child's best interest to involve the caregiver, the caseworker should try to identify another trusted adult in the child's life to provide informed consent, along with the child's written assent. If this is not possible, a child's informed assent may carry due weight⁶² if the caseworker assesses the child to be mature enough, and the caseworker can proceed with care and treatment under the guidance and support of his/her supervisor. In these situations, caseworkers should consult with their supervisors for guidance.

⁶² Due weight refers to the proper consideration given to the child's views and opinions based on factors such as his or her age and maturity.

5 CASE MANAGEMENT FOR CHILD SURVIVORS

NOTE

Caseworkers are required to follow these informed consent/assent procedures and guidelines during the case action planning step when referrals for additional services take place.

OLDER ADOLESCENTS (AGES 15–17)

Older adolescents, ages 15 years and above, are generally considered mature enough to make decisions. In addition, 15-year-olds are often legally allowed to make decisions about their own care and treatment, especially for social and reproductive health care services. This means that older adolescents can give their informed consent or assent in accordance with local laws. Ideally, supportive and non-offending caregivers are also included in care and treatment decision-making from the outset and provide their informed consent as well. However, decisions for involving caregivers should be made with the child directly in accordance with local laws and policies.

If the adolescent (and caregiver) agrees to proceed, the caseworker documents their informed consent using a client consent form or documenting on the case record that they have obtained verbal consent to proceed with case management services.

SPECIAL SITUATIONS

If it is not in the best interest of the child to include a caregiver in the informed consent process, the caseworker needs to identify whether there is a trusted adult in the child's life who can provide consent. If there is no other trusted adult to provide consent, the caseworker needs to determine the child's capacity in decision-making based on their age and level of maturity.

If a child under 15 does not assent but caregivers do OR if both the child and caregiver do not consent OR the child above 15 does not consent, the caseworker needs to decide on a case-by-case basis and based on the child's age, level of maturity, cultural/traditional factors, the presence of caregivers (supportive), and the urgency of care needs, whether it is appropriate to go against the wishes of the child and/or caregiver to proceed with case management and assisting the child so that they can receive needed urgent care and treatment services.⁶³

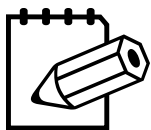
⁶³ Reference **Chapter 4** for more discussion on this key issue. The decision to go against children and/or caregiver's wishes is a serious decision which should be determined, in large part, by the urgency of the child's needs (for example, to secure their immediate safety and/or to mobilize life-saving medical interventions).

In situations where children and/or caregivers are hesitant to proceed, caseworkers should ask additional questions to determine the cause of the hesitation to receive services. Perhaps, for example, the child and/or caregiver are afraid of losing their confidentiality because of a mandatory reporting law. In this situation, the caseworker can further discuss the client's right to participate in how to share information if warranted (e.g., in a mandatory reporting situation) and/or further discuss the risks of reporting. If serious risks are identified, then it may not be in the best interest to report, and the caseworker can further explain and discuss this with the child client and subsequently with his/her supervisor. Caseworkers should take the time to discuss the child's and caregiver's fears and concerns around proceeding with case management, and provide clear and accurate answers to help address these specific fears and concerns.

SNAPSHOT OF INFORMED CONSENT/ASSENT GUIDELINES

AGE GROUP	CHILD	CAREGIVER	IF NO CAREGIVER OR NOT IN CHILD'S BEST INTEREST	MEANS
0–5	-	Informed consent	Other trusted adult's or case-worker's informed consent	Written consent
6–11	Informed assent	Informed consent	Other trusted adult's or case worker's informed consent	Oral assent, Written consent
12–14	Informed assent	Informed consent	Other trusted adult's or child's informed assent. Sufficient level of maturity (of the child) can take due weight.	Written assent, Written consent
15–18	Informed consent	Obtain informed consent with child's permission	Child's informed consent and sufficient level of maturity takes due weight	Written consent

5 CASE MANAGEMENT FOR CHILD SURVIVORS



TOOL: SAMPLE INFORMED CONSENT/ASSENT AND CLIENT RIGHTS STATEMENT

The following sample script can accompany an informed consent/assent form used in your practice setting.



SAMPLE SCRIPT INFORMED CONSENT/ASSENT AND CLIENT RIGHTS STATEMENT

The script below should accompany an informed consent/assent form used in your practice setting.

Hello [name of client].

My name is [name of staff] and I am here to help you. I am a caseworker with [name of agency] and my role is to help children and families who have experienced difficulties. Many children benefit from receiving our services. The first thing we will do is talk about what has happened to you. The purpose of doing this is for me to learn about your situation so we can provide you with information about the services available and help you connect with these service providers. The benefits for receiving case management services include helping you access [insert description of services available such as medical, psychosocial, legal/justice, and safety opportunities in your community]. There are limited risks to receiving case management services [insert risks based on your local settings/program].

It is important for you to know that I will keep what you tell me confidential, including any notes that I write down during case management. This means that I will not tell anyone what you tell me or any other information about your case, unless you ask me to, or it is information that I need to share because you are in danger. I may not be able to keep all the information to myself, and I will explain why. The times I would need to share the information you have given me is if:

- » I find out that you are in very serious danger, I would have to tell [insert appropriate agency here] about it.
- » Or, you tell me you have made plans to seriously hurt yourself, I would have to tell your parents or another trusted adult. If you tell me you have made a plan to seriously hurt someone else, I would have to report that. I would not be able to keep these problems just between you and me.
- » [Explain mandatory reporting requirements as they apply in your local setting].
- » [Add any other exceptions to confidentiality. For example, in cases of UN or NGO workers perpetrating sexual abuse and exploitation].

- » There is another person or agency that can provide you with the support you need, and I have your permission to share your case with them. We will talk more about this later in our discussion.

Therefore, we will not take any action in relation to your matter without your agreement, unless we need to in order to protect your safety and comply with the law.

Before we begin, I would also like to share with you your rights as we work together. I share this same information with everyone I speak with:

- » You have the right to refuse to have your whole story—or parts of your story—documented on case forms. It's okay if there is something you want to tell me, but you'd rather I not write it down while we talk.
- » You have the right not to answer any question that I ask you. You have the right to ask me to stop or slow down if you are feeling upset or scared.
- » You have the right to be interviewed alone or with a caregiver/trusted person with you. This is your decision.
- » You have the right to ask me any questions you want to, or to let me know if you do not understand something I say.
- » You have the right to refuse case management services and I will share with you other options for services in the community.

Do you have any questions about my role and the services that we can offer you?

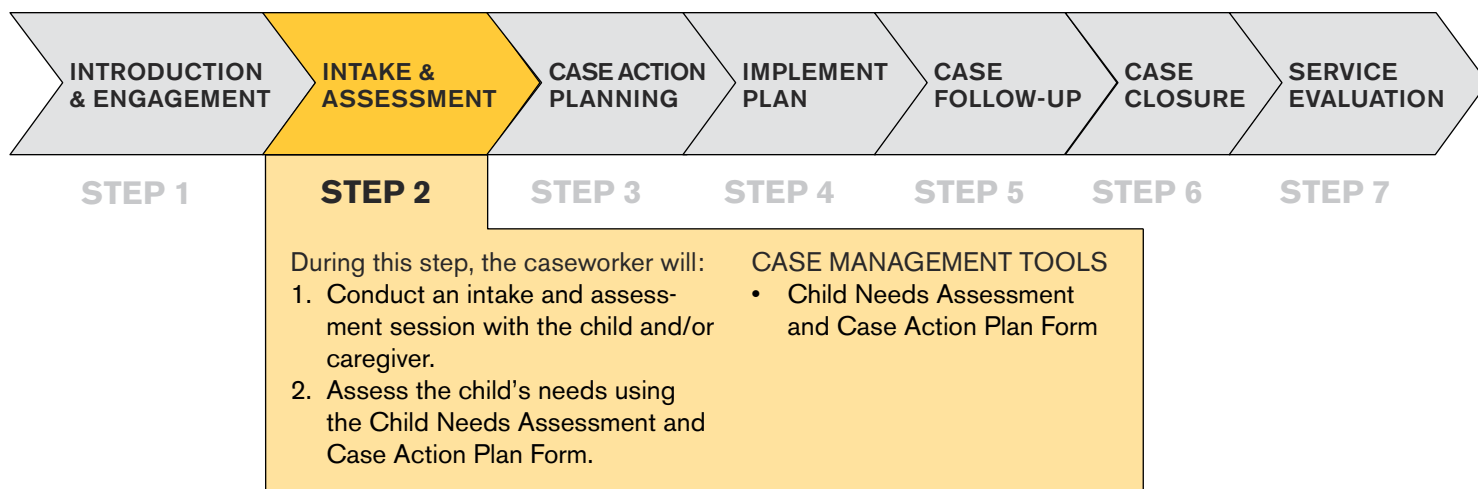
[Allow for time to answer any questions the child and caregiver may have before moving forward to obtain their informed consent/assent to proceed].

May I have your permission to proceed with case management services at this time?

- » If **YES**, ask the child and caregiver to sign the informed consent/assent form for engaging in case management and proceed with case management services.
- » If **NO**, provide information about other case management, safety, health and legal/justice services in the community.

In most situations, children and caregivers will be willing to give their informed consent and/or assent to participate in case management services. The caseworker should be skilled in presenting the information included in the sample statement above in a non-threatening and supportive way. Children and caregivers should feel more secure in talking with a caseworker and proceeding with case management once they have full and complete information. In each local context, caseworkers will adjust their words and approaches to fit the context. This style of local adaption is encouraged by the author of these guidelines.

STEP 2: INTAKE AND ASSESSMENT: UNDERSTANDING THE SITUATION AND IDENTIFYING NEEDS



1. CONDUCTING THE INITIAL INTAKE AND ASSESSMENT INTERVIEW

Once caseworkers have established rapport with child/caregiver clients and gained their consent to initiate case management services and proceed with an assessment, caseworkers should prepare the child for a semi-structured assessment interview with the goal to understand the child and their situation in order to determine the child's main care and treatment needs.⁶⁴ Guidelines for how to establish an ideal context and process for conducting an intake and assessment interview based on the child's age, mental and developmental stage, and context of disclosure can be found in Chapter 3: Engaging and Communicating with Child Survivors.

⁶⁴ In settings where case management services are in place, caseworkers may expand the initial assessment interview to include a more comprehensive assessment of the child's psychosocial needs. A more detailed psychosocial assessment tool, the 'Child and Family Psychosocial Needs Assessment' is explained in Chapter 6.



Illustration by Abdifatah Abdukadir Osman

GOAL AND PURPOSE OF THE INTAKE AND ASSESSMENT INTERVIEW

The goal and purpose of the initial intake and assessment is to safely and slowly assess the child's situation—and his/her experience of sexual abuse—to help determine the child's and family's immediate and eventually, longer-term needs. While it is often necessary for caseworkers to gently inquire about the child's experience of sexual abuse during this step, it is not necessary to elicit every single specific detail about the sexual abuse. Very detailed questions about the child's sexual abuse should be asked once a safe and trusting relationship has been established between the caseworker and the child survivor, and only when the child is ready and wants to share such details. Moreover, caseworkers should already know how the child has been referred to them for services. If the child has already been to the police, a health worker or child protection staff, and was referred to the caseworker by another service provider, caseworkers should be cautious when asking the child questions about their sexual abuse. Ideally, in a situation where a child has already received services and is being referred for ongoing psychosocial support, the option of gathering information from health or child protection service providers already involved in the child's case should be explored, if it is safe and approved by the child and family. This prevents children from unnecessarily repeating their stories. Caseworkers can also gather information from trusted adults (such as the parent) accompanying the child before talking with the child about sexual abuse. This allows the caseworker to better understand the situation and then guide the discussion toward information that still needs to be understood to help the child.

DEFINITION OF ASSESSMENT

The act of gathering information or data at a given moment of time and evaluating it for the purpose of making an appropriate decision about a course of action.

5 CASE MANAGEMENT FOR CHILD SURVIVORS

If caseworkers are unable to obtain such information or are in a position where they need to repeat an intake and assessment, caseworkers must explain to the child the purpose of the discussion. By doing this, caseworkers can immediately dispel the child's fears that they are being asked again about their sexual abuse because someone does not believe them, or any other fears they may have. Children, similar to adults, are empowered and feel safer when they know the purpose of actions taken with them.

A basic principle is that good case management rests on good intake and assessment. Caseworkers are responsible for assessing the child's situation to meet the immediate and longer-term needs of the child and family. This is a key part of their case management responsibilities. In the initial aftermath of sexual abuse, the priority-need areas to assess are the child's health and safety needs. Longer-term needs, such as access to justice and the need for targeted and ongoing psychosocial services can take place once the initial crisis period has ended or when it is most appropriate to do so.⁶⁵ The areas to focus on during the initial intake and assessment include:

- » Developing a context for the child and his/her situation.
 - Child's family composition and current living situation.
 - Understanding what has happened to him/her.
 - Understanding who the perpetrator is and whether he/she can access the child.
 - Understanding if the child has already received care and treatment.
- » Assessing the child's potential needs concerning:
 - Immediate safety risks and needs.
 - Appropriate medical care and treatment.
 - The child's psychosocial status and functioning.
 - The child's/family's desire to pursue legal/justice services.

The assessment areas above are not exhaustive. They are meant to help a caseworker guide an initial intake and assessment interview to direct immediate care and treatment decisions.



HELPFUL TIP

If a child appears to be resistant to answering questions and/or is simply unprepared to talk about abuse, the caseworker should try to identify any factors that may be preventing the child from talking (for example, the caregiver in the room or public interview space, etc). If there are no obvious factors preventing the child from talking, the child simply may not be ready to answer the questions being asked. Under no circumstances should the caseworker force the child survivor to answer questions before the child is ready.

⁶⁵ If a child is referred for ongoing psychosocial support and the crisis period for organizing urgent safety and medical interventions has been addressed, caseworkers can focus on a more holistic psychosocial assessment, found in Chapter 6.

DEVELOPING A CONTEXT FOR THE CHILD

First and foremost, caseworkers should understand their child clients and the main problems they face. The caseworker can begin to build this understanding by having a conversation with the child and/or caregiver about why they are seeking services. In cases of child sexual abuse, caseworkers will need to understand some context for the abuse. For example: 1) who the perpetrator of the abuse is; 2) the last time the abuse happened; and 3) other details which can best inform the urgency of certain interventions such as medical treatment.

Some guiding questions that caseworkers should consider for developing a “context” or understanding of the child and his/her situation are:

- » What is the child’s name? How old is the child? (Although this should already be known from the introduction and engagement step.)
- » What is the child’s current living situation? Who lives in the house with them? Does the child have a place to live? Where does the child live?
- » What is the family situation? Does the child have parents/caregivers? Does the child live with the caregivers? Is there a caregiver with the child now? Does the child have someone in his or her family that they trust?

The purpose of beginning the assessment session within these main assessment areas is to first learn basic, yet essential, context (i.e. understanding) for the child. This also allows the caseworker to begin an assessment with questions that are not as threatening and/or scary as it may be for the child to be asked directly about the abuse he or she has experienced.

UNDERSTANDING WHAT HAPPENED (NATURE, TIMING OF SEXUAL ABUSE)

One of the more difficult aspects of the intake and assessment interview can be talking with the child about the sexual abuse he/she has experienced. Yet, gathering certain information about the child’s experience of abuse is vital to determining the urgency of the child’s health and safety needs. Caseworkers must use utmost caution when starting a conversation with a child about his/her sexual abuse experiences. Caseworkers should carefully follow the communication principles and guidelines for asking questions outlined in Chapter 3, and watch the child closely for any signs of discomfort. If the child expresses verbally or non-verbally that he/she is not comfortable answering questions or telling you information about his/her experiences, caseworkers are advised to respect the child and stop. Forcing a child to disclose their story of abuse is harmful, and caseworkers are strongly advised against this. Many children, given proper time and space to develop trust in the caseworker, will open up to share about what happened. It may be necessary for the caseworker to explain to the child that “we can always come back

5 CASE MANAGEMENT FOR CHILD SURVIVORS

to this at a later point” if he/she is not ready to answer a specific question and then redirect the conversation to a less threatening topic. Overall, the areas of focus for caseworkers in order to understand what happened include:

- » Nature of abuse. In other words, what happened? While caseworkers do not need to ask many details about the violence, it is crucial to find out if physical force was used and whether there was vaginal/anal penetration. Immediate medical care and treatment is highly indicated in these circumstances.
- » Date(s) of the last incident. Knowing the last incident date is essential to analyzing the urgency of a medical referral and for accurately informing the child and caregiver about medical options. Different medical treatments are available depending on the date of the last incident.⁶⁶

UNDERSTANDING WHO PERPETRATED THE ABUSE AND THEIR ACCESS TO THE CHILD

Gathering information about the alleged perpetrator helps in evaluating a child's and family's risks for future harm by the perpetrator and/or friends and relatives of the perpetrator. For example, if the child has been sexually abused by a close neighbor or member of the child's family, the child may not be able to return home. Key areas for assessment include:

- » What is the relationship of the perpetrator to the child survivor and his/her family? In other words, does the closeness of this relationship have implications for safety risk or potential for trauma-related effects?
- » Where is the perpetrator (if the child/family knows) and can the perpetrator access the child easily?
- » What is the occupation of the perpetrator (his/her position—and level of power—could raise safety concerns)?
- » What is the caregiver's capacity to protect the child from this perpetrator?
- » How many perpetrators are involved (this information may be gathered in additional sessions/interviews with a child survivor as part of their overall care and treatment)?

⁶⁶ Note: The child may have a history of abuse. Questions related to the child's past history of abuse should be asked after immediate needs related to the current incident of violence have been resolved. Children should not be forced to recount every incident of abuse during an initial interview, as this can cause emotional and psychological distress.

IDENTIFYING IF THE CHILD HAS ALREADY RECEIVED CARE AND TREATMENT SERVICES

The caseworker should assess if the child has already received services in relation to incidents of abuse. This information both helps the caseworker understand who the child has already come into contact with, and also impacts the development of the case action plan. For example, if a child has been referred to the caseworker after receiving clinical care and treatment for sexual assault, the child will not need a medical referral. And as highlighted earlier, if a child has already received care and treatment from another service provider, it may be possible to explore the option of gathering assessment information from health or child protection service providers already involved in the child's case. This prevents children from unnecessarily repeating their stories.

OTHER INFORMATION SHARED BY THE CHILD

During the assessment step, the caseworker may come to learn many other details about the child and his/her situation. All the information shared between a child and caseworker can help the caseworker (and child as well) deepen each other's understanding of what happened. This understanding is crucial to identifying the main needs of the child and developing an action plan that is realistic and based on said needs. Once the caseworker has assessed the situation and has a baseline understanding of what has happened to the child, they can move into the final assessment stage, whereby each priority need (safety, medical care, psychosocial and legal/justice) is assessed and further action steps determined.

2. ASSESSMENT OF THE CHILD'S MAIN CARE AND TREATMENT NEEDS

Once the caseworker has a deeper understanding of the child (and caregiver) client and his/her situation, it is necessary to move into the phase of the intake and assessment session which focuses on the assessment of the child's main needs. Gaining an understanding of the child's story should always be accompanied by a final needs assessment (focusing first and foremost on health and safety needs) and the development of an action plan to help the child with identified needs. The Child Needs Assessment and Case Action Plan form has been developed to help caseworkers guide the immediate needs for the child. This form is meant to be used to document the main summary of the child's needs assessment as well as the corresponding action plan to meet the identified need.

5 CASE MANAGEMENT FOR CHILD SURVIVORS

CHILD SAFETY ASSESSMENT

MAIN ASSESSMENT POINT: DETERMINE IF THE CHILD IS SAFE

Determining the child's current safety is the most important priority assessment area that must be completed before the child leaves the meeting with the caseworker. In cases of child sexual abuse, especially if the sexual abuse happened at home or with a family member, caseworkers should ask the child (if age six or above) about their safety concerns privately. This allows the child to speak without a parent/caregiver in the room and may elicit further information that would not have been obtained otherwise. If a child refuses to speak with the caseworker alone, and/or the child and caregiver appear upset or agitated, then the caseworker should use his/her judgment and determine whether to proceed with the safety assessment jointly. The guiding assessment areas to evaluate are the:

- » **Child's sense of personal safety in the home environment.** Sample questions include: "Does anyone at home scare you?", "When you are at home do you worry that you will be hurt?", "Does the person who hurt you visit your home?"
- » **Child's sense of personal safety in the community environment.** Sample questions include: "When you are walking to school, do you fear anything or anyone?", "Do you ever feel scared outside of your home... if yes, where?", "What is it like at your school?", "Do you feel safe at school?"
- » **Child's identified safety/support systems.** Sample questions include: "Who do you feel safe with?", "When you have a problem, who do you talk to?" and "Who do you trust at home?"

Child safety assessments require the caseworker to analyze information gathered during the initial intake to help determine safety risks and needs, including family risk factors. In cases of child sexual abuse involving a close male relative, caseworkers should be alert for other kinds of violence, including domestic violence, physical abuse and/or serious neglect. Specific risk factors that must be assessed include:

- » Indications of violence or abuse occurring within the family.
- » Caregiver's/family's willingness to protect the child from further abuse.
- » Access of the perpetrator/perpetrators to child and/or caregivers.
- » Child's and caregiver's perceived sense of safety.

Safety risks for children may be hidden. Depending upon the child's age and developmental stage, the caseworker may have to adapt their questions in order for the child to understand. The most important question for caseworkers to answer during the safety assessment is whether or not the child is safe from further abuse. The caseworker should evaluate the child's situation with the goal of answering these questions:

- » Is there evidence that the caregivers cannot or will not protect the child?
- » Is the child safe at his/her place of residence (e.g., can he/she return home?)
- » Can the perpetrator easily access the child where he/she lives?
- » Is the child fearful of family members or does he/she indicate that he/she does not want to return home?
- » Have any other safety risks become apparent during the assessment interview?

Based on the information gathered and the discussion between the caseworker and child client, the caseworker will document the safety assessment summary in **Section A. Child Safety Assessment**.

Child Needs Assessment and Case Action Plan	
A. CHILD SAFETY ASSESSMENT	
Main Assessment Point: The child's current safety status.	
<input type="checkbox"/> Yes, the child is safe. Please explain in the box.	<input type="checkbox"/> No, the child is not safe. The following safety risks have been identified: <ul style="list-style-type: none"> <input type="checkbox"/> Child's caregivers cannot or will not protect the child from further abuse. <input type="checkbox"/> The perpetrator lives with the child/can easily access the child at home. <input type="checkbox"/> The child is fearful of family members and does not want to return home. <input type="checkbox"/> Other reason (please identify) _____

CHILD HEALTH NEEDS ASSESSMENT

MAIN ASSESSMENT POINT: IDENTIFY IF A MEDICAL REFERRAL IS NEEDED

Determining whether a medical referral is needed is of primary and crucial importance in the assessment of children who have experienced sexual abuse. The urgency of medical referrals is determined by the presence of injuries and/or complaints of pain and/or the timing of the assault and/or nature of the assault and/or for evidence collection. If a sexual assault has occurred within the past 120 hours, an urgent medical referral is needed, since this is within the window of time for the provision of lifesaving treatment. If more than 120 hours have passed, a

5 CASE MANAGEMENT FOR CHILD SURVIVORS

medical referral may still be urgent with the presence of injury and pain. Urgent (e.g., immediate) medical referral may be necessary for:

- » **Prevention of HIV:** The risk for HIV can be reduced if a survivor is referred for medical care to receive HIV post-exposure prophylaxis within 3 days (72 hours).
- » **Prevention of pregnancy:** The risk for unwanted pregnancy can be reduced if a survivor is referred for medical care to receive emergency contraception within 5 days (120 hours).
- » **Medical stabilization/treatment of acute injury or pain:** Depending on the severity and nature of the injury (i.e., broken bones, wounds or internal injuries), emergent medical attention may be indicated.
- » **Evidence collection:** If the survivor requests evidence collection for legal purposes, it is important that a medical examination be arranged and recorded as soon as possible (within 48 hours). If the survivor has not bathed or used the toilet, sperm can be collected from the mouth for up to 12 hours and from the vagina for up to 48 hours. If there was no penetration, sperm can be found on the body for up to 6 hours. Injuries should be documented in detail.
- » **Please note** that some serious and life-threatening injuries are not easily detected as they may not be physically visible or associated with pain (i.e., internal bleeding to the stomach or brain, fistula, etc.).

NON-EMERGENT MEDICAL TREATMENT

Survivors seeking care more than 120 hours after sexual assault may still require treatment and should not be delayed nor discouraged from seeking medical care. Sexually transmitted infections including chlamydia, gonorrhea, and syphilis should be treated with antibiotics and if left untreated may cause chronic illness or infertility. Vaccination for hepatitis B can be given up to 14 days following exposure. Incontinence of urine or stool may indicate severe complications resulting from injury, such as fistula- or rectal-sphincter damage requiring surgical attention. Long-term emotional and psychological consequences of sexual assault may require anti-depression or anti-anxiety medication. Pregnancy resulting from the sexual assault may be safely terminated up to 22 weeks.

- » **Physical and genital exam:** A physical and/or external genital exam may be necessary to assess injuries. A physical exam may also be reassuring to the survivor to ensure that they are fine physically, not internally injured, and free of infections.
- » **Laboratory tests:** Tests can be done for sexually transmitted infections and pregnancy following sexual assault. HIV testing can be done as early as 6 weeks after assault and should be repeated 3-6 months after the incident. Pregnancy testing can be done one week after the assault.

Based on the above, the caseworker should assess the child's need for a medical referral—and the urgency of such a referral—based on the following assessment criteria:

- » Date/timing of the last incident.
- » Presence of and/or complaint of pain or injury.
- » Request and/or willingness of the child to receive a medical check-up.
- » Options counseling in case of pregnancy (if available).
- » Voluntary HIV counseling and testing service.

URGENT MEDICAL REFERRAL (IMMEDIATE) INDICATED

If the last incident was within 120 hours and/or the child is injured/experiencing physical pain, the child should be immediately referred for emergency medical treatment. If the violence occurred after 120 hours, the child should still be referred for non-emergent medical treatment, physical and genital exam, laboratory tests, evidence collection, and reassurance/support.

NON-URGENT MEDICAL REFERRAL (AS SOON AS POSSIBLE) INDICATED

If the child is physically free of injury and pain, the sexual assault occurred more than 120 hours prior, and the nature of the assault did not include physical violence, touching or penetration, a medical referral may be necessary but not urgent. All sexual assault survivors have a right to health care. All children who have been sexually assaulted and their caregivers should be informed of available health services and given a choice of services to receive. Non-urgent medical referrals may be necessary for non-emergent medical treatment, physical and genital exams, laboratory tests, evidence collection, and reassurance/support.

REFERRAL NOT NEEDED

If the child has already received medical care, or medical care and treatment is not applicable (i.e., the sexual abuse did not involve physical contact), the caseworker must indicate the reason why a referral is not made. Based on the information gathered and the discussion between the caseworker and child client, the caseworker will document the health needs assessment summary in **Section B. Child Health Needs Assessment**.

B. CHILD HEALTH NEEDS ASSESSMENT

Main Assessment Point: Does the child require a health referral?

- | | |
|---|---|
| <p><input type="checkbox"/> Yes, a health referral is needed because:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Last incident was within the past 120 hours <input type="checkbox"/> Child complains of physical pain and injury <input type="checkbox"/> Other reason indicated
(e.g. bleeding or discharge or is requested by survivor) | <p><input type="checkbox"/> No, a referral is not needed because:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Services already received from another agency <input type="checkbox"/> Service not applicable
(e.g. abuse did not involve contact) <input type="checkbox"/> Other reason: |
|---|---|

PSYCHOSOCIAL ASSESSMENT

MAIN ASSESSMENT POINT: DETERMINE THE CHILD'S CURRENT LEVEL OF FUNCTIONING

Note: If the child has urgent medical and/or safety concerns, it may be necessary to assess psychosocial needs during a subsequent meeting with the child.

The experience of sexual abuse has a great impact on children's emotional health, their ability to keep up with day-to-day tasks, and their overall sense of safety in the world. Children communicate their distress most often through changed behavior. Caseworkers begin to understand the child's psychosocial state from the very first meeting with the child. The child's emotional state, his/her facial expressions, body language and other behavior can indicate signs of distress. In addition to observing children on an ongoing basis, caseworkers should conduct a very basic assessment of children's functioning, which includes asking the child and caregivers about changes in the child's behavior since the abuse occurred. Any other concerns the caseworker has about the child's mental state should also be noted at this point (e.g., if the child appears upset, agitated, sullen, fearful, suicidal and so on).⁶⁷

When assessing a child's psychosocial state, caseworkers should explain to children and caregivers the purpose for asking these questions. Caseworkers can begin by making a statement such as, "The experience of _____ can be very scary for children. This can cause children to act differently and feel differently from before the _____ happened. I'd like to ask you some questions about your (or your child's) day-to-day activities now. Is that okay?"

From there, the caseworker can go through key areas including:

- » Has the child stopped attending school?
- » Has the child stopped leaving the house?
- » Has the child stopped playing with friends?
- » Does the child feel sad most of the time?
- » Has the child exhibited changes in sleeping or eating habits?

Assessing these areas helps to determine if the child and/or caregiver perceives significant changes following the abuse experience. The caseworker should also assess the strengths of the child and family, and consider these elements in determining the overall care and treatment for the survivor. While children are deeply affected by the experience of sexual abuse, it is important to remember that children are strong and resilient, and their strengths should be

⁶⁷ On page 130–135 please find additional guidance on how to handle a child who is suicidal.

identified and reinforced throughout their care and treatment. Some questions to guide this part of the psychosocial assessment include:

- » **What do you do when you are scared?** This helps children think about people, places or actions they call upon in times of danger.
- » **Who are some people you feel safe with?** This helps children identify supportive people, such as family members, teachers, friends and neighbors, who can be part of their recovery and healing.
- » **What do you do to make yourself feel safe?** This helps children identify the ways they themselves contribute to their own sense of safety.
- » **What are your interests?** This helps children identify activities they enjoy and feel good engaging in. Building on children's interests helps to reengage them in activities that bring happiness and joy to their daily lives, thus facilitating the healing process.

The information gathered during the psychosocial needs assessment helps the caseworker understand to what extent the abuse is currently affecting the child and what strengths the child and family can call upon during the case management process. Based on the information gathered and the discussion between the caseworker and child client, the caseworker will document the psychosocial assessment summary in **Section C. Child Psychosocial Needs Assessment**.

C. CHILD PSYCHOSOCIAL NEEDS ASSESSMENT	
Main Assessment Point: The child's current emotional state and level of functioning.	
The child's behavior has changed significantly since the abuse in the following ways: <input type="checkbox"/> Stopped going to school <input type="checkbox"/> Stopped leaving the house <input type="checkbox"/> Stopped playing with friends <input type="checkbox"/> Feels sad most of the time <input type="checkbox"/> Exhibits sleeping or eating changes <input type="checkbox"/> Other major changes or difficulties reported:	Describe the child's emotional state (describe expressed or observed emotional state of the child) <div style="border: 1px solid black; height: 100px; width: 100%;"></div>
What is the caregiver's understanding of their child's current functioning? Explain, if possible	List the child/family strong points: (list the positive things that the child/family has to help with healing)

5 CASE MANAGEMENT FOR CHILD SURVIVORS



HELPFUL TIP: RISK ASSESSMENT FOR SUICIDE IN YOUNG PEOPLE

Young people, particularly adolescents, may experience very serious reactions to the experience of sexual abuse. It is the responsibility of caseworkers to be watchful for warning signs that a child is at risk of self-harm or suicide. Asking child clients about suicidal thoughts and/or plans can be hard for caseworkers, but it is necessary for addressing a potential crisis situation. Crisis situations, such as a child feeling intense and urgent suicidal thoughts, are largely time-limited and context-specific. With the passage of time and the mobilization of appropriate resources and safety precautions, caseworkers can help children return to pre-crisis levels of functioning.

Crisis response for suicide, if needed, is one component in the overall assessment and treatment plan for a child survivor. Developing basic competence in recognizing and effectively responding to a young person in a suicidal crisis is essential for health and psychosocial staff. Crisis response strategies need to be both clinically sound as well as relevant from a practical standpoint to the particular treatment setting. Basic instructions for crisis response with child clients are outlined below. However, case management and psychosocial agencies should have specific suicide protocols and training for all staff working with children.

If a caseworker becomes concerned that a child is feeling so badly they are thinking about suicide, it is important to begin to assess the potential seriousness of such feelings and thoughts immediately. It can be expected that children, especially adolescents, will have feelings of wanting to die or “disappear” after being sexually abused. In situations where children express feelings of wanting to die, the main task of the caseworker is to determine whether or not this is feeling only, or a feeling with an intention to act (i.e., the intention to actually take one's life). In order to determine this, caseworkers will need to walk through a series of steps to assess risk. These steps include:

- » **Step 1:** Assess current/past suicidal thoughts
- » **Step 2:** Assess risk: lethality and safety needs
- » **Step 3:** Address feelings and provide support
- » **Step 4:** Formulate a safety action plan

STEP 1

ASSESS CURRENT/PAST SUICIDAL THOUGHTS

- A. Explain to the child: “I’m going to ask you some questions that may be hard for you to answer, but I am worried about you, so I want to know that you are going to be ok.”

- B. Ask the child questions that can help you assess his/her suicidal thoughts. This will be different from one culture/context to another. Some sample questions include:
- Do you think about dying? Or wish you were dead?
 - Have you thought about hurting or killing yourself recently?
 - Do you ever wish you could go to sleep and just not wake up? How often? Since when?
- C. Based on the child's responses, you may or may not need to continue with the suicide risk assessment.
- If a child answers "no" and there is no evidence to suggest the child is intending to harm or kill him/herself, it is likely the risk of suicide or self-harm is low. In this case, the caseworker will likely discontinue the assessment. Again, this is determined on a case-by-case basis and whether or not there is other evidence the child is indeed suicidal.
 - If the child answers "yes" to either of the questions, say to the child, "Please tell me more about these thoughts" and then proceed to Step 2.

STEP 2

ASSESS RISK: LETHALITY AND SAFETY NEEDS

While children often say "no" when asked if they have a plan to commit suicide, caseworkers should gently probe the child for clues to determine if the child has a plan. The caseworker also should assess past suicide attempts. Before asking children questions, caseworkers should reassure children that it is okay to have feelings of sadness or wanting to die. Children will need to feel that the caseworker understands them and their feelings, and they are not being judged for them. This will help the child feel safe and comfortable to open up further. Probing questions can include:

- » "Tell me about how you would end your life. [Allow child to answer]. What would you do? When did you think you would do it? Where did you think you would do it? Are (guns/pills/other methods) (at home/easy to get)?"
 - » "Have you ever started to do something to end your life but changed your mind? Have you ever started to do something to end your life but someone stopped you or interrupted you? What happened? When was that? Tell me how many times that happened."
- A. If the child is unable to explain a plan for how they would take their own life and/or if the child has not yet attempted, the risk is less immediate. At this point, the caseworker should support the child by exploring with the child skills for coping with difficult feelings and thoughts, and if needed, develop a safety plan with him/her (see Step 4).
- B. If the child is able to explain a plan and/or indicates they have already attempted suicide, the risk is more immediate. Caseworkers should continue to Step 3.

5 CASE MANAGEMENT FOR CHILD SURVIVORS

STEP 3

ADDRESS FEELINGS AND PROVIDE SUPPORT

- A. It is critical for caseworkers to stay calm if children express suicidal thoughts and a plan. Caseworkers should not try to talk the child out of harming themselves, nor offer advice about what they should do. This feeling of wanting to die serves a purpose for the child—it's a last attempt to feel that they are in control of something.
- B. Caseworkers should tell the child: "I understand that you are feeling this way and I am sorry. I know that it was hard for you to share that information. You are very brave for telling me. It is important to me that you do not hurt yourself. And I would like us to come up with a plan together for how we can help you to not do this. Is this okay with you?"
- C. Formulate a safety plan with the client. Continue to Step 4.

STEP 4

FORMULATE A SAFETY ACTION PLAN

Safety planning is an important tool. A safety plan is a tool for the child and caseworker to use to keep the child safe from harm. Caseworkers need to work with the client to ensure that he/she feels comfortable carrying out whatever plan is negotiated. A child's views, opinions and thoughts help to determine the safety plan developed. Some components of the safety plan are:

- A. Help the child identify warning signs with these sample questions:
 - "Tell me what happens when you start to think about killing yourself or wanting to hurt yourself? What do you feel? What do you think about? How will you know when you are going to need to use this safety contract?"
- B. Help the child identify strategies to feel better:
 - Explain to the child: "We want to find other things that you can do to make yourself feel better."
 - Ask the child:
 - "When you have thought about killing yourself before, what prevented you from doing it?"
 - "Tell me some things that you can do to help feel better when you start to think about hurting yourself or wanting to end your life. What has helped you feel better in the past? Is there someone you can talk to or go to?"
 - Based on what the child says, agree with the child that he/she will use these strategies / do these helpful things instead of hurting him/herself.

C. Identify a safety person:

- Explain to the child that we want to be assured that he/she is safe. In addition to the strategies the child has to feel better, explain that the child's parent or another safe person must be notified to act as a "safety person" for the child.
- Say to the child: "We want to help you stay safe. At times, we use family members to help us keep you safe. Can you think of someone in your family who could stay by your side? Can we work together to get that family member to agree to stay by your side in order to keep you safe?"
- Identify a safe person who can be with the child 24/7 to ensure the child does not harm him/herself.

HANDLING AN IMMEDIATE CRISIS SITUATION

If a child appears to be in active crisis (very upset with active suicidal thoughts and a plan, is threatening and/or exhibits out of control behavior, or appears to be in danger), follow these steps:

- A. Stay calm and reassure the child you are happy they shared this crisis with you and you want to help them. Do not yell, react strongly, or get angry with the child.
- B. Explain to the child you would like to talk with your supervisor right now. Contact your supervisor immediately. Talk to your supervisor while the client is still working with you. Decide, or agree on a plan BEFORE the child leaves.
- C. If you cannot get in touch with your supervisor and the child does not have someone who can be with them 24/7, arrange for the client to be referred immediately to the health clinic or somewhere safe and supervised until you can contact your supervisor. This may require the caseworker to stay with the child if there are no other options.

SUPPORT FOR CASEWORKERS

Working directly with young people who are at heightened risk for suicide and suicidal behavior can be very challenging on a number of levels. Those practicing in rural and remote contexts often face unique challenges related to issues of isolation and limited resources. Ethical and legal challenges including issues of confidentiality and informed consent always need to be managed when working with children (and adults) at-risk for suicide. Therefore, individual caseworkers must have close supervision while working with a young person who is actively suicidal. It is recommended that caseworkers have their supervisor and/or another caseworker review the risk assessment and develop the action plan before the child leaves the service providing agency/caseworker; furthermore, every decision should be talked through with another professional. This helps to share the burden and decision-making responsibilities that service providers have while caring for a young person who is suicidal.

5 CASE MANAGEMENT FOR CHILD SURVIVORS

IDENTIFYING LEGAL/JUSTICE NEEDS AND AN ACTION PLAN

MAIN ASSESSMENT POINT: DETERMINE THE CHILD'S AND CAREGIVER'S INTERESTS IN PURSUING LEGAL ACTION THROUGH THE AVAILABLE JUSTICE SYSTEM

The decision to pursue justice is an important one, and families need to have access to full information to think through such a decision. It is common for families to take some time to come to a decision. During the initial assessment, caseworkers should ask general questions about the child's/family's interest in pursuing a justice response (if such a response is even possible).

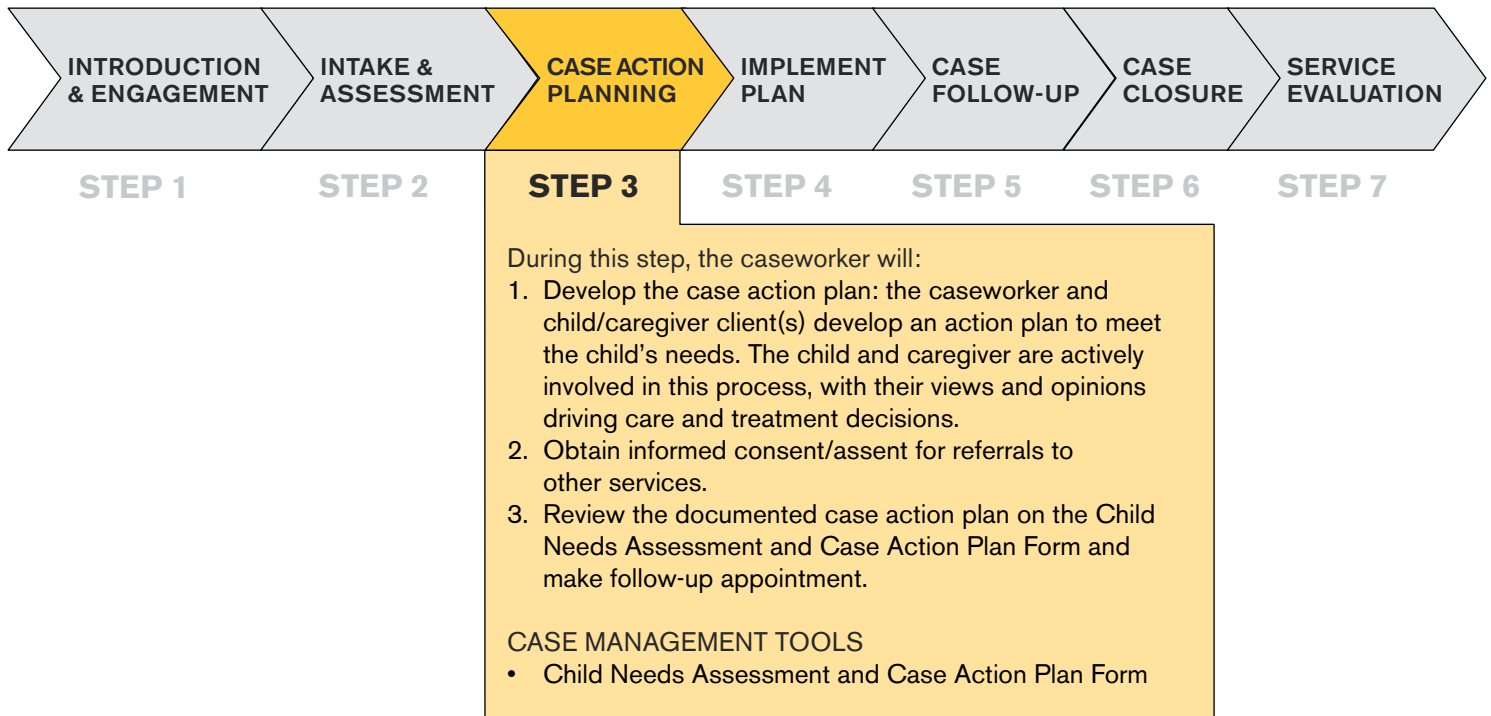
Caseworkers, therefore, need to know the options for pursuing justice in a particular setting. If a legal aid center exists, children and caregivers should be referred to this agency for a full explanation of options. The caseworker can document legal referrals in **Part D: Legal Needs and Assessment**.

D. CHILD LEGAL NEEDS ASSESSMENT AND ACTION PLAN	
Legal Referral Made? <input type="checkbox"/> Yes <input type="checkbox"/> No	If NO, why not?
If YES Child client is referred to:	
Child will be accompanied by	

CHECKLIST FOR STEP 2: INTAKE AND ASSESSMENT

- ☐ Do you have an understanding of who your child client is, and what his/her family and living situation is like?
- ☐ Do you have an understanding of what happened, and what the child's experience of abuse has been?
- ☐ Do you know who the perpetrator is, and whether or not he is able to access the child?
- ☐ Do you know if the child has already received services from another agency?
- ☐ Have you assessed the child's needs according to the four main areas (safety and medical treatment as the priority)?
- ☐ Have you completed a risk assessment if your client expresses thoughts of suicide?
- ☐ During the intake and assessment session did you remember to:
 - ☐ Follow the interview guidelines outlined in Chapter 3. Key considerations are to:
 - o Allow the child to have someone present.
 - o Talk in a private and safe location.
 - o Have a choice for a female/male caseworker (as available).
 - ☐ Collect only the details of the incident relevant to helping the child and his/her family.
 - ☐ Allow the child to tell his/her story at his/her own pace. Do not force the child to answer questions he/she is not comfortable answering.
 - ☐ Explain that the care and treatment referrals will focus on identifying priority needs (safety, health, psychosocial, and legal/justice) the child/family has.

STEP 3: DEVELOP CASE GOALS AND ACTION PLAN



1. DEVELOP THE CASE ACTION PLAN

In conjunction with the initial intake and assessment step, caseworkers develop a case action plan with the child and his/her caregivers based on the main needs that emerge during the assessment. To the greatest extent possible, a case action plan is developed before the child leaves the caseworker's office. Case action plans are developed according to identified needs and based on the wishes and needs of the child clients and/or caregivers; they focus on key goals often related to medical care, safety, etc. These goals are broken down further into specific tasks that are allocated to the caseworkers and child/caregiver clients to complete within a certain time frame. The case action plan is also documented on the Child Needs Assessment and Case Action Plan form.

A case action plan for a child survivor will likely comprise referrals for services as well as direct services (e.g., psychosocial) provided by the caseworker. Developing the child's case action plan is a process that focuses on identifying immediate needs after sexual abuse in the four main areas of assessment (with priority needs in **bold**):

- » **Safety and protection from further abuse.**
- » **Clinical health care and treatment.**
- » Psychosocial support⁶⁸.
- » Access to justice.

HELPFUL TIP

If other child protection concerns are noted during the assessment (for example, a child is the head of household, engaged in child labor, or living on the streets), it will be necessary to include referrals to the local child protection agency for management of these serious concerns.



The Child Needs Assessment and Case Action Plan form guides the caseworker through the four main areas always assessed following an incident of sexual abuse. It may be useful for caseworkers to use this form to guide them as they go through a step-by-step process with the child/caregiver to develop an individualized case action plan⁶⁹ for a child client. The case action plan section of the tool provides a written record of the plan, which the caseworker and child client develop together to meet the health, safety, psychosocial and legal/justice needs identified during the assessment interview and case action planning process.

ACTION PLANNING FOR SAFETY

Based on the assessment of the child's safety situation, the caseworker and the child client/caregiver will have determined if the child is safe or not. If during the assessment it is determined that the child is NOT SAFE, the caseworker should prioritize with the child the development of the safety action plan. For a child who is not safe, an action plan must be in place before the child and caregiver leave the interview meeting. The following steps are for developing a safety action plan:

⁶⁸ Note: While the Child Needs Assessment and Case Action Plan form described above only assesses the immediate needs of survivors with regard to their experience of violence, children may also require more specific psychosocial care than what can be offered in standard case management services. Assessing the psychosocial care needs of children and families should be undertaken only by service providers with capacity to offer more advanced services as part of their case management. Assessing psychosocial needs and a suggested set of psychosocial interventions are explained in more depth in Chapter 6.

⁶⁹ Note that organizations may use different names for the case action plans: case plans, care plans, support agreements or action plans. They all refer to the same element.

5 CASE MANAGEMENT FOR CHILD SURVIVORS

STEP 1

Based on the identified safety risks to the child and/or caregiver, develop an action plan that includes a combination of referrals to protection and security agencies and the development of an individual safety plan. For example, if a child reports that he/she is being harassed by the perpetrator's family members when he/she is walking to and from school, then steps to decrease the child's risk for harassment should be put in place. Ideas should come from the child, the caregiver and the caseworker. In this situation, some possible ideas include: 1) making sure the child does not walk to and from school alone; 2) making sure the child does not walk at night by him/herself; and 3) practicing with the child how he/she will respond to contact with the perpetrator and when he/she perceives immediate danger.

STEP 2

Document the safety referrals and discuss and agree upon an individual safety plan.

E. CASE ACTION PLAN REVIEW AND FOLLOW-UP MEETING		
This Assessment and Case Action Plan has been developed and agreed by:		
<input type="checkbox"/> Child Client	<input type="checkbox"/> Caregiver/Other Relation: _____	<input type="checkbox"/> Social Worker Code: _____
All relevant consent forms for referral signed: <input type="checkbox"/> Yes <input type="checkbox"/> No		
If not, explain why here:		
Follow up meeting is scheduled for: Date: _____ Location: _____		

ACTION PLANNING FOR MEDICAL CARE

If it is determined that the child requires a medical referral (urgent or non-urgent), the caseworker should document the following in the Health Action Plan section: 1) whether a health referral has been made; 2) if the child needs accompaniment; and 3) who will accompany the child. If for some reason, the child or caregiver refuses a medical referral that is medically indicated, the caseworker must contact their supervisor immediately to determine the necessary actions to safeguard the best interest of the child (e.g., to save his/her life).

If the child has already received medical care or if medical care and treatment are not applicable, e.g., the sexual abuse did not involve physical contact, the caseworker must indicate the reason why a referral was not made.

HEALTH ACTION PLAN	
Health Referral Made? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES Child client is referred to: Child will be accompanied by	HEALTH REFERRAL NEEDED, BUT NOT MADE BECAUSE: <input type="checkbox"/> Referral declined by survivor <input type="checkbox"/> Service Unavailable <input type="checkbox"/> Referral refused by caregiver <input type="checkbox"/> Non-urgent referral made Explain:
Note: In cases of medical emergency, <u>it is in the child's best interest to receive life-saving care</u> . If a caregiver or child refuses the referral, a supervisor must be contacted immediately and/or a referral made if the child's life is at risk.	

ACTION PLANNING FOR PSYCHOSOCIAL CARE

Based on the child psychosocial assessment, the caseworker develops an action plan with the child and caregiver to promote the child's psychosocial health and well-being. The Psychosocial Action Plan includes core interventions from which all children and non-offending caregivers can benefit in the aftermath of sexual abuse. They are:

- » **Providing emotional support.** This means being a nonjudgmental, friendly person in abused children's lives who can talk with them at their pace and on their level. Emotional support for children requires repeated reinforcement that the sexual abuse is not their fault; that they are strong and can heal; that they did the right thing by speaking up; and that people support and believe them.
- » **Providing basic education about sexual abuse.** This helps children understand and manage their reactions, and provides them with very specific information about the impact of sexual abuse and the strategies to manage the impact of abuse. How to provide children with information and education about sexual abuse is outlined in **Chapter 6**.
- » **Assisting the child with specific problems.** In some settings, children may not be allowed to return to school if it is public knowledge they have experienced abuse or if they are pregnant as a result. They may feel shame about returning to their place of worship or "being seen" in the community generally, or they may have other personal issues. One of the best ways for children to heal from sexual abuse is to resume their daily activities, such as attending school, going to the market with their mother, and participating in religious and community gatherings. Caseworkers must work with children to develop strategies to help them reconnect with their friends, family and community.

All sexual assault survivors have a right to health care. All children who have been sexually assaulted and their caregivers should be informed of health services available and given a choice of services to receive.

5 CASE MANAGEMENT FOR CHILD SURVIVORS

- » **Providing counseling to the caregiver and/or other family members.** The child is affected by how the people closest to them treat them after sexual abuse. Many parents have strong reactions when learning their child has been sexually abused. Parents may also have misinformation about sexual abuse which causes them to blame or become angry with their child. If this is happening, caseworkers may need to provide counseling to the family. Counseling should focus on allowing the caregivers to openly (and not in front of the child) share their feelings about the abuse and how this is affecting them AND provide caregivers with information, support and education on how to care for themselves and their child.
- » **Crisis intervention for children with suicidal thoughts.** Based on the intake and assessment interview, any interventions required for a young person expressing suicidal thoughts must be integrated into the overall psychosocial action plan.

PSYCHOSOCIAL ACTION PLAN	
<input type="checkbox"/> Provide emotional support. <input type="checkbox"/> Provide education and counseling about sexual abuse to help children and families understand and manage reactions. <input type="checkbox"/> Assist the child with any problems identified in the assessment above (going back to school, etc)	<input type="checkbox"/> Provide counseling with caregiver and/or other family members. <div>Describe why this is needed and how it will be done here:</div>

ACTION PLANNING FOR LEGAL/JUSTICE NEEDS

The decision to pursue justice is a big one, and families need to have access to full information to think through such a decision. It is common for families to take some time to come to a decision. During the initial case action plan, it is perfectly acceptable to present legal options to the child client and caregiver and then allow them time to discuss the options together.

Caseworkers therefore need to know the options for pursuing justice in a particular setting. If a legal-aid center exists, children and caregivers should be referred to this agency for a full explanation of options. In **Part D: Legal Needs and Assessment**, caseworkers document any legal referrals made.

D. CHILD LEGAL NEEDS ASSESSMENT AND ACTION PLAN	
Legal Referral Made? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES Child client is referred to: Child will be accompanied by	If NO, why not?

2. OBTAIN INFORMED CONSENT/ASSENT FOR REFERRALS TO OTHER SERVICES

KNOWING SERVICES IN YOUR COMMUNITY

In many situations, children and families will need support from more than one agency because of their varied needs. Therefore, caseworkers will need to know which agencies are child-friendly and how to provide the child and family members with complete information about the referral agencies (including the potentially negative as well as positive consequences of the referral).⁷⁰ This information is shared during the discussion between the child and caseworker on their identified needs and existing options for help. **Explaining referral options fully and accurately is part of obtaining informed consent from the client for the referral, and preparing them for what will happen.**

OBTAINING INFORMED CONSENT/ASSENT FOR REFERRALS

Caseworkers must have in-depth knowledge of the services agencies can provide, to empower children and help caregivers make informed choices in their best interest. Before referring children to other services, caseworkers need to obtain informed consent/assent for doing so. To obtain informed consent/assent appropriately, caseworkers should follow the guidelines outlined in step one of case management. As always, caseworkers should provide information in a neutral and nonjudgmental manner, never “demanding” that a child or caregiver take a particular action. The information caseworkers share to help children and caregivers decide on referrals should include the following:

- » Full and complete information about the specific options for medical care, safety assistance, legal counseling and assistance, and psychosocial services. This requires explaining, and/or discussing with the child/caregiver, the following:
 - What will happen as a result of the referral.
 - Which information will be shared about the case in the referral process.
 - What is going to happen to him/her.
 - The benefits and risks of an intervention (medical treatment, safety assistance, and so on).
 - That he/she has the right to decline or refuse any part of an intervention provided by the case worker and/or referral agency.
- » Decide what information will be shared about the case in the referral process.

⁷⁰ In your setting, community-based referral procedures should be documented in a GBV referral pathway, and should include protocols for information sharing and data collection across agencies. If these procedures and protocols do not exist, it is the responsibility of the leading GBV agency to initiate this process.

5 CASE MANAGEMENT FOR CHILD SURVIVORS

1. EXPLAIN WHAT WILL HAPPEN/WHAT IS GOING TO HAPPEN/BENEFITS AND RISKS

Especially in regard to health and police/protection referrals, caseworkers should fully prepare the child by giving him or her detailed information about what to expect and what the child's rights are in the process. For example, to prepare a child for a medical examination and treatment, the caseworker should:

- » Explain what will happen during each step of the examination, why it is important, what it will tell the doctor and how it will influence the care the child will receive.⁷¹
- » Reassure the child that he/she can have a caregiver and/or a caseworker present (if permitted at the medical facility). From there, the caseworker should ask the child who he/she wants present and include this in the case action plan.
- » Explain the benefits of receiving medical care and the risks of not receiving care. For example, if the child has been raped within the past 120 hours and has started menstruating, there is a risk of pregnancy. It is therefore important to explain the benefit to medical treatment (the option to prevent an unwanted pregnancy) and the risk of not receiving medical treatment (pregnancy).
- » Explain what the caseworker will do after the referral takes place.
- » Encourage the child to ask questions about anything he/she does not understand or is concerned about during the examination.

2. DECIDE TOGETHER WHAT INFORMATION WILL BE SHARED

Mutual expectations about the handling of case notes and case information must be discussed and agreed upon by all the partners in a referral network. It is important that everyone is clear about process, procedure, and protocol. This will ensure that services are not duplicated and quality standards for confidentiality, safety, information sharing and core principles of care for child survivors will be maintained.

With explicit protocols in place, caseworkers can discuss with children and caregivers which information they would like to share with the respective referral agencies. In each setting and with each child client, such information will differ slightly. The main point is that this discussion should happen with the child and caregiver before the referral takes place, as part of the informed consent/assent procedure. Some sample questions to guide this discussion are:

- » Which information, if any, would the child/caregiver like to share with the referral agency?
- » How would the child/caregiver like that information to be shared? For example, would the child client prefer a written document (such as a referral form) or would they like the

⁷¹ Note: This same information should be shared when the child is with the health care staff during the standard clinical care informed consent procedures.

caseworker to accompany them and information directly at the time of their appointment? Would they like to have their case information given to a referral agency with them present [or not]?

- » What is the time frame for sharing information with the service provider? If a child client gives permission for information to be shared with another service provider, it is important to discuss how long this consent to share information is valid. For example, “consent” may only be for a one-time referral and not to share any further information about the child and his/her situation after that one referral is made.

3. MAKE ACCOMPANIMENT PLANS FOR REFERRALS

Children should not be sent to referral agencies alone, unless they are adolescents and there is good reason to do so. Generally, children should be accompanied by their caregivers, and if appropriate, their caseworkers. In some settings, GBV caseworkers are known in the community and, therefore, even the simple act of a caseworker walking a child to a medical facility or police station automatically raises curiosity and may inadvertently break confidentiality. Always use strategies that safeguard children's confidentiality throughout the referral process; identifying the appropriate person to accompany the child is an important consideration.

As part of the informed consent discussion, the caseworker should provide support and guidance for negotiating the varying opinions to make sure decisions are indeed in the child's best interests.

3. REVIEW THE CASE ACTION PLAN AND NEXT STEPS

Once the caseworker and the child client/caregiver have gone through each assessment need and developed an action plan, the case worker should conduct a final review of the documented case action plan with the child client and/or caregiver. This is also the time to ensure that all relevant consent forms are signed for the referral agencies needed to carry out the case action plan. If everyone agrees with the plan developed, the caseworker should indicate this review and agreement in Section E: Case Action Plan Review and Follow-Up Plan (see below). From here, the caseworker should also schedule a follow-up meeting with the child and caregiver.

5 CASE MANAGEMENT FOR CHILD SURVIVORS

SCHEDULING A FOLLOW-UP MEETING

If scheduling a follow-up visit is possible, the caseworker should discuss with the child and caregiver how best to make arrangements. Questions to ask the child are:

- » Can you visit the child/family at their home? Note: If it is possible to visit the child at home without creating safety risks and/or breaching confidentiality, caseworkers should do so. Visiting a child in his or her environment helps to improve the caseworker's understanding of the child client.
- » If a home visit is possible, what should you say when you arrive? How should you explain your visit (maybe the client or caregiver would like you to pretend to be a school aid or other official)?
- » Before the visit, should you contact the caregiver first? Should you look for the child at home or at school? These details need to be discussed to ensure that confidentiality is protected and the child/caregiver knows what to expect.

If the child client doesn't want you to visit him or her at home, make agreements for a second meeting at the counseling center or another location. Make an appointment for a specific day and time. Ask what the child wants you to do if he or she cannot come to the meeting at the appointed time. The follow-up meeting date and plan should be documented in Section E: Case Action Plan Review and Follow-Up Plan (see below).

E. CASE ACTION PLAN REVIEW AND FOLLOW-UP MEETING

This Assessment and Case Action Plan has been developed and agreed by:

☐ Child Client

☐ Caregiver/Other

☐ Social Worker

Relation: _____

Code: _____

All relevant consent forms for referral signed: ☐ Yes ☐ No

If not, explain why here:

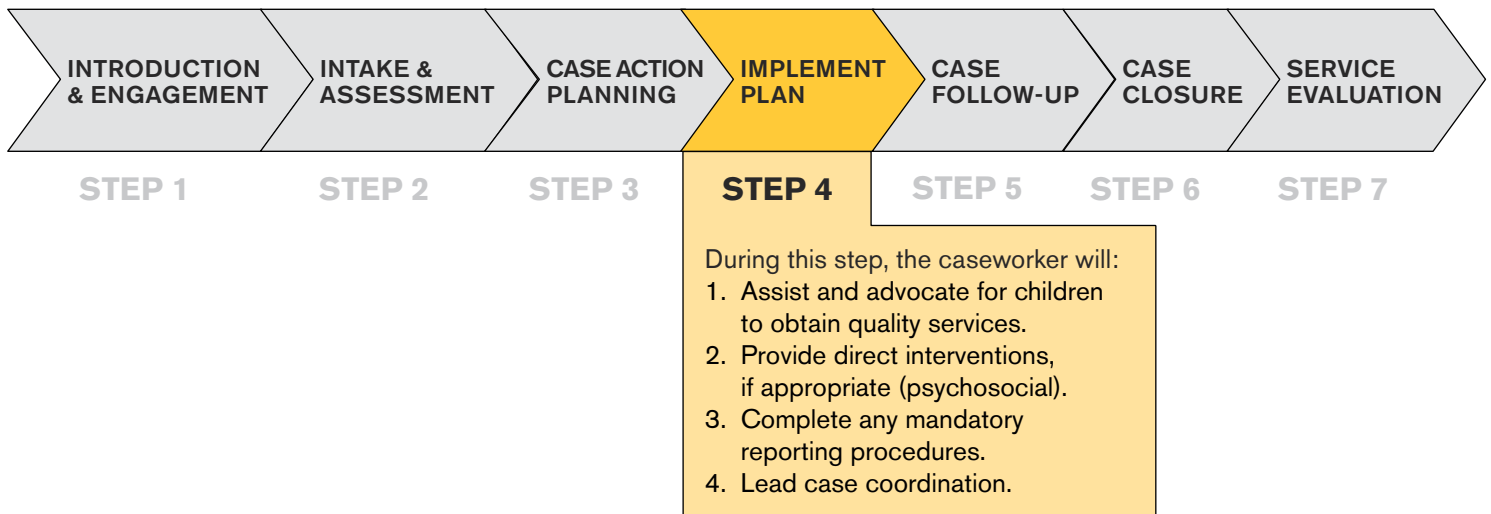
Follow up meeting is scheduled for: Date: _____

Location: _____

CHECKLIST FOR THE CASE ACTION PLANNING PROCESS

- ☐ Have you evaluated the child's needs according to the four main areas (safety and medical treatment as the priority)?
- ☐ Have you explained options for service providers to help meet the child's needs?
- ☐ Have you made plans for how the child will be referred safely (e.g., who will go with the child)?
- ☐ Have you agreed with the child and caregiver which information will be shared with the different referral agencies?
- ☐ Have you obtained informed consent/assent correctly?
 - ☐ From the right person (child and/or caregiver)?
 - ☐ Provided a full and complete explanation of the options for help, as well as risks and benefits, what will happen, etc.?
 - ☐ Are the consent forms signed by the appropriate person?
- ☐ Have you documented the action plan and provided the client with a copy (if safe and possible to do so)?
- ☐ Have you made a follow-up appointment?
- ☐ Have you consulted with your supervisor regarding urgent safety concerns raised during the assessment interview and case action planning process?

STEP 4: IMPLEMENT THE CASE ACTION PLAN



Once the initial assessment and case action planning steps are complete, it is time to **implement the action plan**. Typically, children and families require assistance with accessing other services (for example, referrals for safety interventions and medical care). In many settings, caseworkers will directly provide psychosocial support and similar services, as well as link children and families with other agencies.

1. ASSIST AND ADVOCATE FOR CHILDREN TO OBTAIN QUALITY SERVICES

Based on the action plan created between the child and caseworker, the caseworker will carry out his or her responsibilities related to helping obtain the necessary services. There are many different ways the caseworker can assist the child and caregiver with obtaining services. Typical actions include:

- » Accompanying children/caregivers to the police, health and other service providers.
- » Advocating on behalf of the child. Some common examples are advocating:
 - With police and security personal to take protective measures;
 - For compassionate and quality medical care and treatment;
 - For children's views and opinions to be taken into consideration in actions that affect their life and well-being.
- » Meeting with service providers (e.g., health workers) to explain what happened and provide information about the abuse so the child is not forced to repeat their story (which information the caseworker shares should already have been discussed in the case action planning process).

2. PROVIDE DIRECT INTERVENTIONS (PSYCHOSOCIAL)

For case management agencies also providing direct psychosocial interventions, caseworkers conduct psychosocial interventions during this step.⁷² Providing direct interventions is not the same as referring a child for psychosocial support, for example, to a child-friendly center. While connecting a child to activities in their community and/or helping the child to resume normal activities like attending school are vital needs, these actions are part of the action plan/referral process for helping the child obtain services (unless the organization offers these services as well). Direct psychosocial interventions are interventions provided by the caseworker directly to the child and/or family. Examples of direct psychosocial interventions include:

- » One-on-one sessions with the child client to provide a space for understanding the abuse and sharing information and education with the child about sexual abuse and common reactions.
- » Family meetings to discuss specific problems or issues happening in the family because of the sexual abuse (e.g., parents needing additional support and information to help their child).
- » Sharing with the child ideas and tools for reducing stress and anxiety they may feel after the abuse.
 - Other interventions that your program specifically offers.

NOTE ON CLIENT ADVOCACY

Client advocacy often takes place throughout a child's case management process. Providing response services according to best practice can be difficult in settings where there is a general lack of understanding and/or resistance to talking about sexual violence towards children. Therefore, in humanitarian aid settings, program supervisors may need to support advocacy efforts with service providers to ensure best practice protocols are being discussed and promoted at all levels.

⁷² If case management agencies do not currently provide specific psychosocial interventions to child survivors of sexual abuse, but would like to, please refer to **Chapter 6**.

3. COMPLETE MANDATORY REPORTING PROCEDURES

Part of the caseworker's responsibility is to complete any mandatory reporting procedures that are required in a particular setting. Mandatory reporting requirements to the police or other actors will have already been discussed with the child and caregiver in the initial assessment and case action planning steps. Based on the requirements in the local setting, caseworkers or supervisors are responsible for completing the necessary reports. The child and caregiver must be fully aware of the process, procedures and protocol, as highlighted in Chapter 4.

4. LEAD CASE COORDINATION AND CASE CONFERENCING

It is the role of the caseworker to lead case coordination and case conference efforts on behalf of the child client.

Case coordination includes communication, information sharing and collaboration, and occurs regularly with case management and other staff serving the child client within and between agencies in the community. Coordination activities may include directly arranging access to services; reducing barriers to obtaining services; establishing linkages; and other activities recorded in progress notes. This is a key role of the caseworker in helping the child receive the appropriate services he/she needs, as described above.

Case conferencing differs from routine coordination. Case conferencing is a more formal, planned and structured event, separate from regular contacts. Case conferences are usually interdisciplinary, and include one or multiple internal and external providers and, if possible and appropriate, the client and family members and any other close supporters.

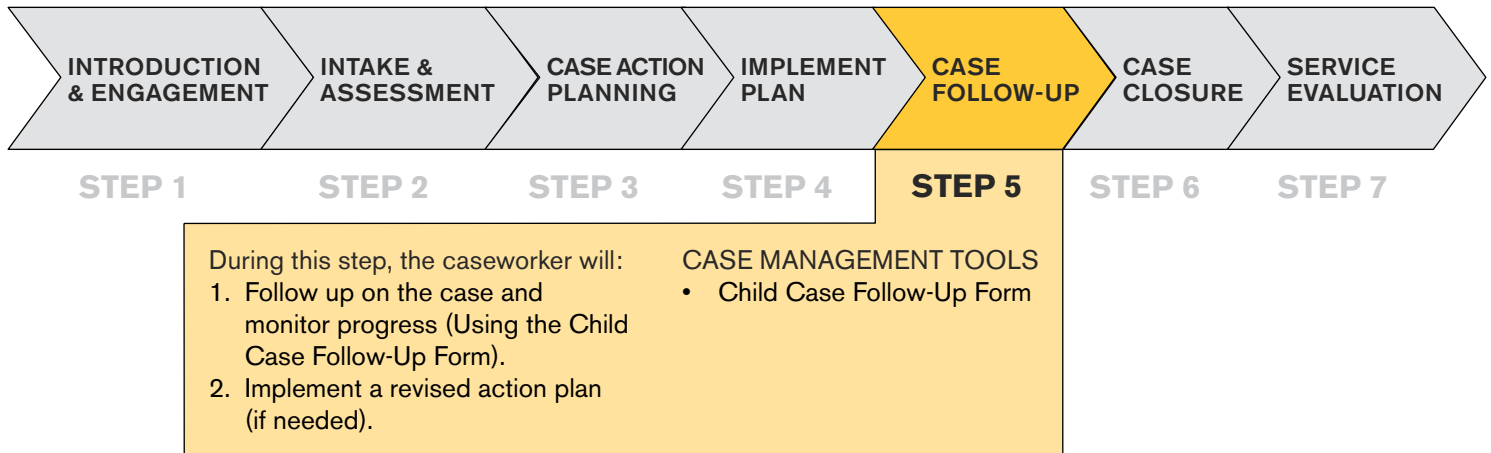
Case conferences are oftentimes scheduled when the child's needs are not being met in a timely or appropriate way. The purpose of the case conference is to gather the appropriate service providers (and concerned support people in the child's life as appropriate) to identify or clarify ongoing issues regarding the child client's status. Case conferences provide the following opportunities: 1) to review activities including progress and barriers towards goals; 2) to map roles and responsibilities; 3) to resolve conflicts or strategize solutions; and 4) to adjust current service plans.

Case conferencing can be very effective in providing a child client with more holistic, coordinated and integrated services across providers; it also reduces the duplication of efforts.

CHECKLIST FOR IMPLEMENTING THE ACTION PLAN STEP

- ☐ Have you implemented the action steps you are responsible for as the case-worker? This includes leading the coordination of referral services by:
 - ☐ Directly arranging services/appointments.
 - ☐ Accompanying the child to services.
 - ☐ Advocating on behalf of the child client.
- ☐ Have you completed any mandatory reporting requirements for which you are responsible?
- ☐ Have you provided additional psychosocial support services that your agency offers? For example:
 - ☐ Family counseling.
 - ☐ Individual support and counseling for the child.
 - ☐ Relaxation training.
 - ☐ Other child activities.
- ☐ Have you arranged for case conferences with other service providers, if needed?

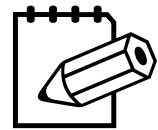
STEP 5: CASE FOLLOW-UP AND MONITORING PROGRESS



1. CASE FOLLOW-UP AND MONITORING PROGRESS

The caseworker should have already agreed upon times and mechanisms for case follow-up with the child and caregiver during the initial assessment and case action planning process. Follow-up meetings should take place in a location where the child is comfortable and confidentiality can be protected. Follow-up visits should have a specific time, date and place based on individual needs. The main purpose of the case follow-up visit is to ensure the child has received needed services and to assess any improvement in the child's situation. Follow-up visits allow the child client and the caseworker to "update each other" on actions taken since the first meeting and discuss longer-term needs and care, among other things. Follow-up visits also provide the opportunity for caseworkers to re-assess the child's safety situation. In addition, the caseworker may revisit the access-to-justice option if needed.

CHILD CASE FOLLOW-UP FORM TOOL



The CCS Case Follow-Up form is a tool for caseworkers providing case management to child survivors of sexual abuse. The Child Case Follow-Up Form builds upon the initial assessment and case action planning tool described in Steps 2 and 3.

PART I: ADMINISTRATIVE INFORMATION

Part I of the CCS Case Follow-Up Form is where the caseworker fills in the survivor and caseworker codes set up during the initial visit. Below that, the caseworker fills out the date, time and location of the visit (home, counseling center, etc.). This information helps the caseworker and case management supervisor keep track of the timeliness and location of visits, etc.

PART I: Administrative Information		
Survivor Code:	Incident ID:	Caseworker Code:
Date:	Time:	Location:

PART II: PROGRESS TOWARD GOALS

Part II of Child Case Follow-Up Form is where the caseworker documents progress made toward the initial safety, health, psychosocial and justice/legal goals outlined in the initial case action planning step. For example, if the child needed medical care and planned to visit the health clinic with his mother, the caseworker should follow up during the case follow-up visit to find out if the medical care was received, and if so, detail the experience. For each goal that has been met, the caseworker checks the “MET” box and explains how the goal was met. If the goal has not been met, the caseworker checks the “NOT MET” box and explains why. Evaluating progress toward the initial goals helps the caseworker and child agree on how to move forward.

5 CASE MANAGEMENT FOR CHILD SURVIVORS

PART II: Progress towards Goals			
Evaluate Progress made towards GOALS agreed on in the Assessment & Case Action Plan Form	Not Met	Met	Explain
Safety			
Health Care			
Psychosocial Support			
Access to Justice			
Other (list other goals made here)			

PART III: RE-ASSESSING SAFETY

Assessing a child's physical and emotional safety takes place at every visit during case management. Children's risks of harm often increase once sexual abuse has been disclosed; therefore, asking children about their sense of safety should be ongoing. Often, it is necessary to ask children questions about safety in private, so he/she can speak freely about family members, caregivers, or other sensitive topics. During follow-up visits, caseworkers should ask specific questions, such as:

- » Do you [still] feel safe at home? Who makes you feel safe? Do you feel safe at night? Is there any person at home that makes you feel afraid? Has your feeling of safety changed [at all] since we last met?
- » Do you feel safe in the community? At school? Do you walk to school alone? Do you walk in the community after dark? Do your friends or neighbors play with you?

These questions can help caseworkers to indirectly determine the child's level of emotional and physical safety. Sometimes it is necessary for adults to help children identify unsafe situations such as walking home from school alone. Make every attempt to determine if the original safety

issues have been resolved (note: This is already addressed in Part II: Progress Towards Goals in the CCS Case Follow-Up form.)

Based on the outcome of the safety re-assessment, follow-up safety referrals or an updated safety plan may be necessary. Or, the caseworker may need to further advocate on behalf of the child and family with the local police to support the child's request for protection.

PART III: Re-Assessing Safety	N	Y	Explain	Additional Intervention Planned
Are there new or continued risks of danger at home?				
Are there any new safety issues the child is facing in the community?				
Other Safety Concerns?				

PART IV: FINAL ASSESSMENT

In the final assessment stage of the follow-up visit, caseworkers and the child client review the information gathered during the follow-up visit in order to determine priorities for moving forward. Based on the information gathered during the meeting, the caseworker should complete the six sections (a through f) in the table below to determine if the particular situation is stable or not. This is where the caseworker documents new goals and action steps required for helping the child client.

PART IV: Final Assessment	N	Y	Additional Interventions Planned
a. Child's safety situation is stable Child is physically safe, and/or has a plan to keep him or her physically safe			
b. Child's health situation is stable Child has no medical problems that require treatment			
c. Child's psychosocial wellbeing has improved Child is engaging in regular behavior, can smile and feel happy, has a safe person to talk to			
d. Family situation is stable Child happy and comfortable at home, caregivers not blaming child			
e. Access to Justice secured (if applicable)			

5 CASE MANAGEMENT FOR CHILD SURVIVORS

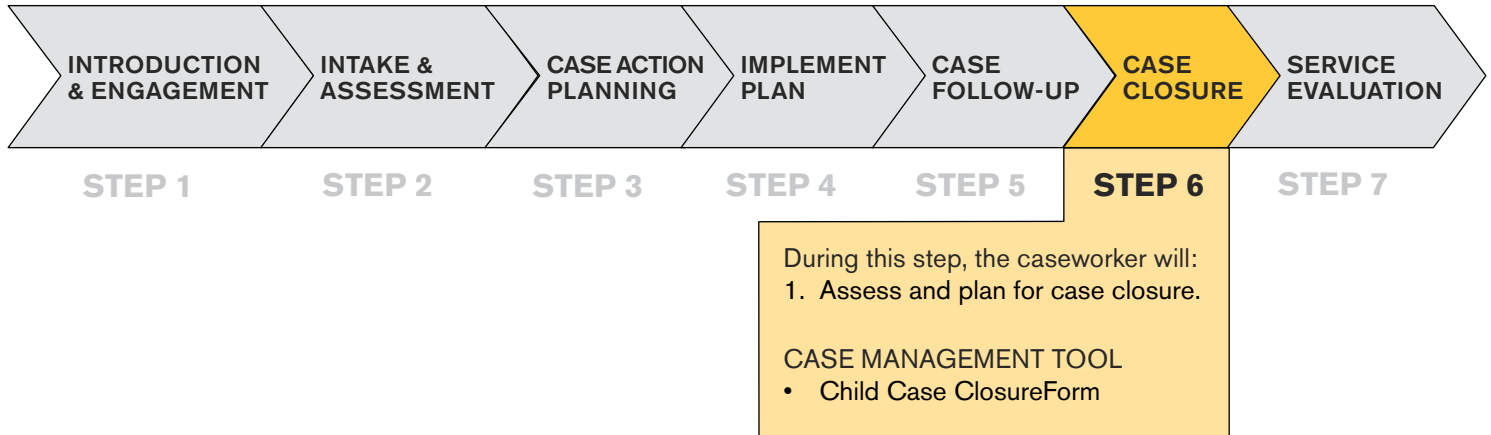
2. IMPLEMENT REVISED CASE ACTION PLAN

Once the follow-up meeting and the final assessment are complete, the caseworker, along with the child and caregiver will once again take steps to implement the revised action plan. Another follow-up visit should be subsequently scheduled, and the follow-up and action planning steps are repeated until the child's entire set of needs are met and no further action is required by the caseworker. Additional informed consent/assent procedures should be followed if new referrals are required.

CHECKLIST FOR CASE FOLLOW-UP AND MONITORING STEP

- ☐ Did you meet with the child client at the requested time and location?
- ☐ Did you review the initial case goals and case action plan to assess the status of the:
 - ☐ Safety and protection situation?
 - ☐ Access to needed medical services?
 - ☐ Psychosocial care provided?
 - ☐ Decision/progress made toward accessing justice?
- ☐ Did you re-assess the child's safety situation to learn about new safety risks emerging since the initial meeting?
- ☐ Did you assess the final status of the child's needs at this time?
- ☐ Have you developed a revised action plan, if needed?
- ☐ Have you followed informed consent procedures, if needed (for new service providers/ referral agencies being brought into the child's care and treatment action plan)?
- ☐ Have you made another follow-up appointment with the child/caregiver?

STEP 6: CASE CLOSURE AND EVALUATING SERVICE



1) ASSESSING AND PLANNING FOR CASE CLOSURE

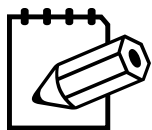
It is important that caseworkers know when their work is finished with children and families affected by sexual abuse. This is not always easy to determine. While the case management process looks linear, service providers need to recognize that children's lives are rarely so straightforward, and most often involve a complex mix of legal, medical, safety and psychosocial issues and needs. Caseworkers should be prepared to revisit the process several times during their contact with child survivors. When cases are very complex, and especially where risks are very high, it is likely that a case will remain open for a long time. This is an issue that needs discussion and planning with the case management supervisor to ensure that services are not compromised by an organizational need to close a case before all issues have been worked through.

In contexts where caseworkers may see the child survivor only one time, they must prioritize the assessment and case action planning steps and provide as much information as possible to the child survivors. The caseworker will need to thoroughly document the information provided to the child. The caseworker should keep the case open for a period of 30 days, and then close the case if there is no contact with the child client after 30 days.

In contexts where follow-up is possible, cases should not be closed until the last follow-up is satisfactory. This usually happens when the child's and family's needs are met and/or her (normal or new) support systems are functioning. It is important to make sure that case closure is child-centered and that the child is ready for the case to be closed. When a case is closed, the caseworker should give the child (and caregiver, as appropriate) assurances that he/she is welcome to contact the caseworker in the future if necessary. Service providers need to ensure that their endings with children are timely, appropriate, and allow the possibility of future contact if desired by the client or should circumstances change. Caseworkers should document when a case is closed and the specific reasons for doing so. Case files should generally be closed when:

- » The case plan is complete and satisfactory, and follow-up is finished.
- » There has been no client contact for a specified period (e.g., more than 30 days).
- » The child client and caseworker agree that no further support is needed.

5 CASE MANAGEMENT FOR CHILD SURVIVORS



TOOL: CHILD CASE CLOSURE FORM

To the right is a sample case closure form that can be adapted across settings.

CHECKLIST FOR CLOSING THE CASE STEP

The caseworker can document the main reasons why the case was closed, and follow the case closure checklist to remember the key actions which should take place prior to case closure.

They are:

- ☐ Child's needs have been met.
- ☐ Child's safety plan has been reviewed and is in place.
- ☐ Child (and caregiver) has been informed he/she can resume services at any time.
- ☐ Case supervisor has reviewed case closure/exit plan.



HELPFUL TIP

Children may experience violence and abuse in the future, sexual or otherwise. Therefore, children and their trusted caregivers should be reassured that they are welcome to receive services again and that the agency is on-hand to help at all times.

Incident ID:

Survivor Code:

Child Case Closure Form

Case Worker Code

Case Opening Date

Case Closure Date

CASE CLOSURE

Summarize the reasons why the case is being closed. Comment on the progress made toward goals in the service plan. Where necessary, include provisions for continued services, listing agencies and contact persons.

CASE CLOSURE CHECKLIST

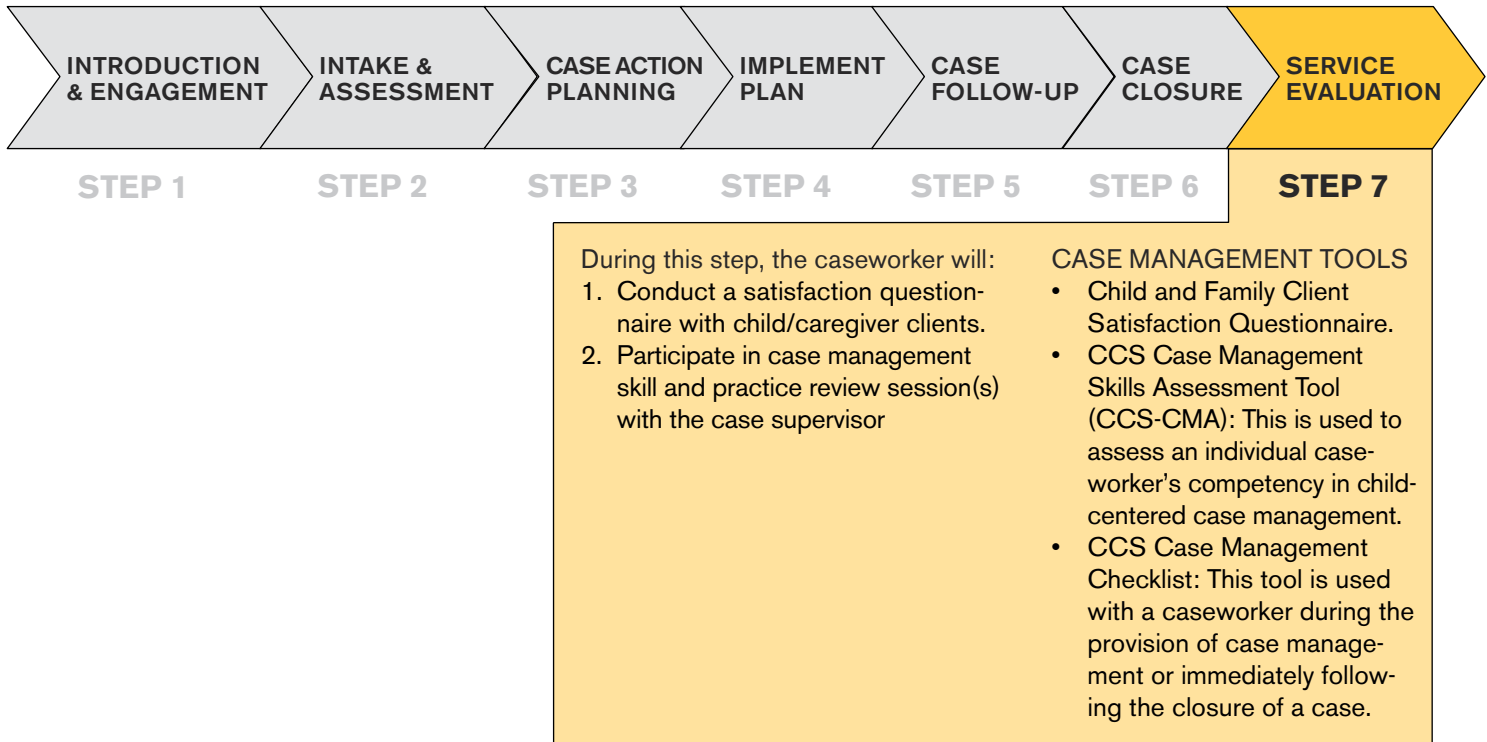
- | | | |
|---|----------|-------------------|
| ✓ Child safety plan has been reviewed and is in place. | Yes_____ | No_____ (explain) |
| ✓ Child/caregiver has been informed she or he can resume services at anytime. | Yes_____ | No_____ (explain) |
| ✓ Case supervisor has reviewed case closure/exit plan. | Yes_____ | No_____ (explain) |

Explanation notes here:

Case Closure Date_____ Case Worker Code_____

Supervisor Signature/Date_____

STEP 7: SERVICE EVALUATION



The final step of case management is to evaluate the services provided. Frequently, the caseworker moves quickly from one client to the next, especially in humanitarian aid settings. Evaluation is undertaken by clients and provides feedback to caseworkers and their agencies on the services received by the clients. Caseworkers may also be involved in evaluation through a final case review and checklist with their supervisor. Ultimately, the most appropriate method for evaluating case management services will be discussed and decided by program managers. Methods will differ depending on the nature of the context—emergency, refugee camp setting, post conflict, etc.

1. CONDUCTING CLIENT SATISFACTION QUESTIONNAIRES

Client feedback forms represent one method for agencies to receive feedback from the children and families being served. The purpose of administering client satisfaction questionnaires is to improve services and better meet the needs of clients. It is not to evaluate individual staff members and should not be used as a staff performance tool. Most often, client feedback forms are completed through an interview with the child survivor and his/her caregiver if appropriate. In general, the guidelines for directly involving and interviewing children as part of a satisfaction questionnaire are:

- If the child is 9-years-old or younger, and the caregiver was actively and positively involved in the child's care and treatment, caregivers should be interviewed only.
- If the child is between the ages of 10–12, and the caregiver was actively and positively involved in the child's care and treatment, caregivers should be interviewed directly. However, children at this age should also be asked for their opinion about the care they received, and if appropriate, can be included in the interview with the caregiver, or interviewed separately. This should be decided on a case-by-case basis.
- If the child is 14-years-old or older (14–18), they are able to be interviewed directly about his/her satisfaction with services provided. If appropriate, a separate interview with the child's caregiver may be useful, if they were actively and positively involved in the child's care and treatment. Generally, adolescents should provide permission to the caseworker before the child's caregiver is approached directly.

OBTAINING PERMISSION (INFORMED CONSENT/ASSENT)

As with all services, caseworkers are required to obtain permission from the child and/or caregiver to conduct the satisfaction questionnaire. Caseworkers should follow the standard guidance for obtaining informed consent/assent from child survivors/caregivers outlined in the beginning of this chapter. Caseworkers should inform survivors that the questionnaire does not include questions about his/her case; it serves only to obtain information about the services he/she has received and all responses will be kept confidential. If the survivor is able to read and write and would like to complete the form on his/her own, this is also acceptable.

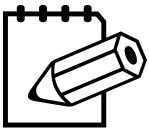
5 CASE MANAGEMENT FOR CHILD SURVIVORS

TIMING OF SATISFACTION QUESTIONNAIRES

Clients generally provide feedback soon after their case has been closed. As always, the needs of the child client should always be considered first and the decision to administer the child client feedback form should be determined on a case-by-case basis. If there is any concern that administering a questionnaire would harm the child client or impact their treatment, the questionnaire should not be administered. As with everything we do, the most important principle to follow is the prevention of any further harm to the child survivor.

WHO CONDUCTS THE QUESTIONNAIRE?

Ideally, someone other than the child/caregiver's direct caseworker should conduct the satisfaction questionnaire. This allows for some degree of independent analysis of client feedback and provides additional comfort to the child/caregiver to share openly how they feel about the services they have received. Service providers will decide specific protocols for conducting questionnaires with clients. For example, will every child client be approached, or only a certain percentage? These are decisions for service providing agencies to make.



SAMPLE CHILD AND FAMILY SATISFACTION QUESTIONNAIRE

Please go to pg 175 to see a sample Child and Family Satisfaction Questionnaire form.

2. SUPERVISION AND ASSESSMENT OF CASEWORKER SKILL AND PRACTICE

Casework is complex and challenging work that requires the ongoing assessment and monitoring of skill and practice. Caseworkers are required to demonstrate competencies in multiple areas, including the knowledge, attitudes and skills covered in Chapters 1–3:

- » Core knowledge about child sexual abuse (as evidenced by the CCS-KA).
- » Child-friendly attitudes and beliefs (as evidenced by the CCS Attitude Scale).
- » Child-friendly communication and engagement skills (as evidenced by the CCS-CA).

In addition to the competencies above, caseworkers must also demonstrate competency in child-centered case management practice, as outlined in these guidelines. This requires supervisors to assess skills and knowledge related to case management practices. The following methods are used to assess case management staff competencies:

1. Implementing a skills assessment tool with individual staff—CCS Case Management Assessment or the “CCS-CMA.”
2. Giving feedback on applied caseworker practice during individual case supervision using the CCS Case Management Checklist.

The section on the next page describes how to use the two staff competencies tools: the CCS Case Management Assessment and the CCS Case Management Checklist. These tools can help case supervisors assess individual staff competencies specific to child case management principles and approaches outlined in Chapters 4 and 5.

full tool at end of chapter

Supervision Tool
Caring for Child Survivors Case Management Assessment
(CCS-CMA)

Date: _____
 Staff Name: _____
 Supervisor: _____

Instructions for Administering the Tool

PURPOSE
 This assessment represents the minimum standards of child sexual abuse case management competencies required for health and social work staff working directly with child survivors of sexual abuse. Competent care rests on service providers knowing how to provide child-centered case management. This is a staff supervision tool for managers/supervisors to use periodically with staff providing care directly to children and families.

INTRODUCTIONS

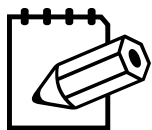
- (1) This supervision tool should be performed through a verbal interview between the staff and his/her supervisor in a quiet and confidential location.
- (2) The supervisor should inform the staff person this tool is being used to assess areas where further capacity building is needed. It is not a performance evaluation tool. The supervisor should explain they will receive a score to determine if individual staff member ‘meets’ the overall case management competency assessment.
- (3) The supervisor asks the staff person to explain/describe the concepts below and score accordingly:
 - **Met:** If the individual is able to answer the questions correctly and fully, they will receive a mark of ‘met’.
 - **Partially Met:** If the individual is able to answer at least 50% of the question, they will receive a mark of partially met. For example, if the question is, “name the guiding principles for working with child survivors” and the person can only name 4, they will receive a ‘partially met’ score.
 - **Unmet:** If the individual is unable to answer the question, they will receive a mark of ‘unmet’.
- (4) Once the assessment is complete, the supervisor will score the assessment and discuss with the staff member his/her scores, what they mean, and any further capacity building needed

Administering the Tool

Case Workers Providing Case Management and/or Psychosocial Services have already Met these Competency Assessments		Yes	No	Not Evaluated
Demonstrate in-depth knowledge about child sexual abuse (as evidenced by the CCS - KA)				
Demonstrate child friendly attitudes and beliefs (as evidenced by the CCS Attitude Scale)				
Demonstrate child friendly attitudes and beliefs (as evidenced by the CCS - CA)				

Case Management Skills	Criteria for Answering Correctly	Met 2 pts	Partially Met, 1 pt	Not Met 0 pts
1. What are the Guiding Principles for Working with Child Survivors	Need to list all guiding principles for full (100%) score. Need to list at least 4 principles for half score (50%) score: 1. Promote the Child’s Best Interests 2. Ensure the safety of the child 3. Provide Comfort & Reassurance 4. Maintain Appropriate Confidentiality 5. Involve the Child in Decision-Making 6. Treat Every Child Fairly & Equally 7. Strengthen Children’s Resiliencies			
2. What are the mandatory reporting requirements in this setting?	1. Needs to be developed locally.			

5 CASE MANAGEMENT FOR CHILD SURVIVORS



SUPERVISION TOOL: CCS CASE MANAGEMENT SKILLS ASSESSMENT (CCS-CMA)

The CCS Case Management Assessment Skills tool (CCS-CMA) can be used by supervisors to measure individual staff members' skills and knowledge on child-centered case management practice. The CCS-CMA is a simple supervision tool to implement. It should be used with staff responsible for providing case management services to child sexual abuse survivors and, if possible, should be administered following a formal training on case management with child survivors.

USING THE CCS-CMA TOOL

STEP 1

Set up an assessment interview session between the supervisor and staff person being evaluated. The assessment interview should take place in a private and quiet space.

STEP 2

Inform the person being evaluated that:

- » The assessment interview is intended to identify areas where additional training on child sexual abuse case management would be beneficial. The purpose of the assessment is to evaluate specific skills on providing case management to children and families affected by sexual abuse.
- » He/she will not be fired if he/she does not fully meet the skill competency assessment. However, he/she will need to demonstrate improved skills over time to avoid consequences.
- » **NOTE:** Supervisors should approach these assessment interviews in a friendly, supportive and relaxed manner. This does not mean the assessment is not taken seriously; rather, a friendly and supportive approach can help ease nervousness and fear a person is feeling.

STEP 3

Implement the CCS-CMA Tool

- » The CCS-CMA Tool is divided into 10 questions on the essential case management knowledge and skill areas described in these guidelines. The supervisor verbally asks the individual to explain the individual points being asked. The supervisor can also ask the individual to role play answers during the assessment to more easily observe skills in action.

- » The supervisor assesses the accurateness of the answer using the CCS-CMA Answer Sheet. Answers are rated according to three possible levels:
- **MET:** If the individual is showing competency in the area correctly and fully, they will receive a mark of “met.”
 - **PARTIALLY MET:** If the individual is able to answer/demonstrate 50% competency in the areas, they will receive a mark of “partially met.”
 - **UNMET:** If the individual is unable to answer/demonstrate competency, they will receive a mark of “unmet.”

Administering the Tool				
Case Workers Providing Case Management and/or Psychosocial Services have already Met these Competency Assessments		Yes	No	Not Evaluated
Demonstrate in-depth knowledge about child sexual abuse (as evidenced by the CCS - KA)				
Demonstrate child friendly attitudes and beliefs (as evidenced by the CCS Attitude Scale)				
Demonstrate child friendly attitudes and beliefs (as evidenced by the CCS - CA)				
Case Management Skills	Criteria for Answering Correctly	Met 2 pts	Partially Met, 1 pt	Not Met 0 pts
1. What are the Guiding Principles for Working with Child Survivors	Need to list all guiding principles for full (100%) score. Need to list at least 4 principles for half score (50%) score: <ol style="list-style-type: none"> Promote the Child’s Best Interests Ensure the safety of the child Provide Comfort & Reassurance Maintain Appropriate Confidentiality Involve the Child in Decision-Making Treat Every Child Fairly & Equally Strengthen Children’s Resiliencies 			

**CCS-CMA
Answer Sheet**
(first page of tool)

STEP 4

Scoring the CCS-CMA Tool

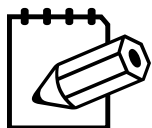
- » The supervisor administering the tool will need to add up the points in each column and then total each column for a final score. Only one score is allowed per question.
- » Final Score:
- **16–20 points: MET** Scores in this range indicate that the staff person has met the core case management requirements and is able to work independently with children and families with ongoing supervision.
 - **8–14 points: PARTIALLY MET** Scores in this range indicate additional training is needed to build knowledge and skills in case management. The staff person should be monitored very closely if working on child sexual abuse cases. A capacity building plan should also be put into place. This may include one-on-one mentoring sessions, additional training opportunities, shadowing fellow staff members, among other capacity building activities.

5 CASE MANAGEMENT FOR CHILD SURVIVORS

CCS-CMA Scoring Section (last page of tool)

TOTAL POINTS			
TOTAL SCORE			
Evaluating Case Management Competency – Instructions for Scoring: 16-20 points: MET: Scores in this range indicate that the staff person has met the core case management requirements and is able to work independently with children and families with ongoing supervision. 8-14 points: PARTIALLY MET: Scores in this range indicate additional training is needed to build knowledge and skills in case management. The staff person should be monitored very closely if working on child sexual abuse cases. A capacity building plan should also be put into place. This may include one-on-one mentoring sessions, additional training opportunities, shadowing fellow staff members, among other capacity building activities.	Final Evaluation: _____ MET _____ PARTIALLY Met _____ UNMET		

- **0–6 Points: NOT MET:** Scores in this range indicate that the staff person does not have sufficient knowledge and skills to provide case management to child survivors. A capacity building plan should be put into place. This may include one-on-one mentoring sessions, additional training opportunities, shadowing fellow staff members, among other capacity building activities. Following additional training, the CCS-CMA tool should be re-administered.



SUPERVISION TOOL: CCS CASE MANAGEMENT CHECKLIST

The CCS Case Management Checklist (CCS Checklist) should be used with caseworkers as part of their ongoing supervision. The checklist can be used throughout a child's case to assess a caseworker's application of skills during each step of the case management process (e.g., intake and assessment step, case action planning step, etc.). This checklist can be used once the caseworker has fully completed the case management services to evaluate the overall skill and practice in an individual case. Moreover, the checklist can also be self-administered for advanced caseworkers. This means caseworkers would refer to the checklist after each meeting with a child to assess their own application of knowledge and skill during case management. If used this way, to be truly reflective of abilities, caseworkers would need to be committed to completing the checklist according to what actually happened, as opposed to what they wish would have happened.

The CCS Checklist guides a detailed conversation between caseworker and supervisor to evaluate the caseworker's practice of applying specialized child sexual abuse knowledge and skills in direct casework.

The checklist goes through specific actions caseworkers should take while providing care and support services to child survivors. Please reference the CCS Checklist on page 183.

CONCLUSION

This chapter outlines the main steps of case management for child survivors of sexual abuse. Guidelines for handling difficult situations (e.g., assessing suicide) and sample case management forms have been provided throughout. Not all of the instructions and tools provided will match every context, and program managers should work closely with their staff in determining how best to integrate the tools, instructions and information in order to improve case management approaches for child survivors.

Overall, best practices and standards for quality child case management practices require that caseworkers have the ability to:

- » Modify communication strategies to engage with children of all levels.
- » Possess and apply child-friendly attitudes with child survivors.
- » Apply technical understanding of sexual abuse to educate and support children throughout the case management process.
- » Adapt case management steps and procedures for child survivors. This includes:
 - Applying the guiding principles for working with child survivors.
 - Modifying informed consent/assent procedures according to local laws and the age and developmental stage of the child.
 - Modifying confidentiality protocols to reflect the limits of confidentiality when working with children.
 - Assessing a child survivor's health, safety, psychosocial and legal/justice needs.
 - Use crisis intervention to mobilize early intervention services to ensure the child's health and safety.
 - Conducting ongoing child safety assessments of family and social contexts after disclosure of abuse.
 - Taking decisive and appropriate action when a child needs protection.
 - Identify strengths and needs and engage the child/family in a strength-based care and treatment process.
 - Proactively engaging caregivers (non-offending) throughout the child's care and treatment.
 - Knowing the child-friendly service providers in the local area.
 - Being able to function independently and collaborate with other service providers.

Incident ID:

Survivor Code:

Child Needs Assessment and Case Action Plan

A. CHILD SAFETY ASSESSMENT

Main Assessment Point: The child's current safety status.

☐ Yes, the child is safe.

☐ No, the child is not safe.

Please explain in the box.

The following safety risks have been identified:

- ☐ Child's caregivers cannot or will not protect the child from further abuse.
- ☐ The perpetrator lives with the child/can easily access the child at home.
- ☐ The child is fearful of family members and does not want to return home.
- ☐ Other reason (please identify) _____

SAFETY ACTION PLAN

Child Safety Plan Describe safety plan here.

Safety Referral Made? ☐ Yes ☐ No

If YES

Child client is referred to:

Child will be accompanied by (describe by relationship e.g., Mother)

IF NO

Why not?

B. CHILD HEALTH NEEDS ASSESSMENT

Main Assessment Point: Does the child require a health referral?

☐ Yes, a health referral is needed because:

- ☐ Last incident was within the past 120 hours
- ☐ Child complains of physical pain and injury
- ☐ Other reason indicated
(e.g. bleeding or discharge or is requested by survivor)

☐ No, a referral is not needed because:

- ☐ Services already received from another agency
- ☐ Service not applicable
(e.g. abuse did not involve contact)
- ☐ Other reason:

HEALTH ACTION PLAN

Health Referral Made?

☐ Yes ☐ No

If YES

Child client is referred to:

Child will be accompanied by

HEALTH REFERRAL NEEDED, BUT NOT MADE BECAUSE:

- ☐ Referral declined by survivor
- ☐ Referral refused by caregiver
- ☐ Service Unavailable
- ☐ Non-urgent referral made

Explain:

Note: In cases of medical emergency, it is in the child's best interest to receive life-saving care. If a caregiver or child refuses the referral, a supervisor must be contacted immediately and/or a referral made if the child's life is at risk.

Incident ID:

Survivor Code:

C. CHILD PSYCHOSOCIAL NEEDS ASSESSMENT

Main Assessment Point: The child's current emotional state and level of functioning.

The child's behavior has changed significantly since the abuse in the following ways:

- ☐ Stopped going to school
- ☐ Stopped leaving the house
- ☐ Stopped playing with friends
- ☐ Feels sad most of the time
- ☐ Exhibits sleeping or eating changes
- ☐ Other major changes or difficulties reported:

Describe the child's emotional state (describe expressed or observed emotional state of the child)

What is the caregiver's understanding of their child's current functioning? Explain, if possible

List the child/family strong points: (list the positive things that the child/family has to help with healing)

PSYCHOSOCIAL ACTION PLAN

- ☐ Provide emotional support.
- ☐ Provide education and counseling about sexual abuse to help children and families understand and manage reactions.
- ☐ Assist the child with any problems identified in the assessment above (going back to school, etc)

- ☐ Provide counseling with caregiver and/or other family members.

Describe why this is needed and how it will be done here:

D. CHILD LEGAL NEEDS ASSESSMENT AND ACTION PLAN

Legal Referral Made? ☐ Yes ☐ No

If NO, why not?

If YES

Child client is referred to:

Child will be accompanied by

E. CASE ACTION PLAN REVIEW AND FOLLOW-UP MEETING

This Assessment and Case Action Plan has been developed and agreed by:

☐ Child Client ☐ Caregiver/Other ☐ Social Worker
Relation: _____ Code: _____

All relevant consent forms for referral signed: ☐ Yes ☐ No

If not, explain why here:

Follow up meeting is scheduled for: Date:

Location:

Child Case Follow-Up Form

PART I: Administrative Information

Survivor Code:

Incident ID:

Caseworker Code:

Date:

Time:

Location:

PART II: Progress towards Goals

Evaluate Progress made towards GOALS agreed on in the Assessment & Case Action Plan Form	Not Met	Met	Explain
Safety			
Health Care			
Psychosocial Support			
Access to Justice			
Other (list other goals made here)			

Other Observations/Case Worker notes

MAKE SURE ANY ADDITIONAL CONSENT FORMS FOR NEW REFERRALS ARE SIGNED

Incident ID:

Survivor Code:

PART III: Re-Assessing Safety	N	Y	Explain	Additional Intervention Planned
Are there new or continued risks of danger at home?				
Are there any new safety issues the child is facing in the community?				
Other Safety Concerns?				

PART IV: Final Assessment	N	Y	Additional Interventions Planned
a. Child's safety situation is stable Child is physically safe, and/or has a plan to keep him or her physically safe			
b. Child's health situation is stable Child has no medical problems that require treatment			
c. Child's psychosocial wellbeing has improved Child is engaging in regular behavior, can smile and feel happy, has a safe person to talk to			
d. Family situation is stable Child happy and comfortable at home, caregivers not blaming child			
e. Access to Justice secured (if applicable)			
f. Other Intervention Needed			

Follow up meeting is scheduled for (date/time/location): _____

MAKE SURE ANY ADDITIONAL CONSENT FORMS FOR NEW REFERRALS ARE SIGNED

Incident ID:

Survivor Code:

Child Case Closure Form

Case Worker Code

Case Opening Date

Case Closure Date

CASE CLOSURE

Summarize the reasons why the case is being closed. Comment on the progress made toward goals in the service plan. Where necessary, include provisions for continued services, listing agencies and contact persons.

CASE CLOSURE CHECKLIST

- | | | |
|---|----------|-------------------|
| ✓ Child safety plan has been reviewed and is in place. | Yes_____ | No_____ (explain) |
| ✓ Child/caregiver has been informed she or he can resume services at anytime. | Yes_____ | No_____ (explain) |
| ✓ Case supervisor has reviewed case closure/exit plan. | Yes_____ | No_____ (explain) |

Explanation notes here:

Case Closure Date_____ Case Worker Code_____

Supervisor Signature/Date_____

SAMPLE Child Client Questionnaire Feedback Form

Overview/Purpose

The purpose of the child client feedback form is to evaluate the services the **[insert agency]** offers to children and families affected by violence and to assess their level of satisfaction with our services. As a **[insert GBV/Child Protection/etc]** program, our main priority is to serve our clients who have suffered from **[insert information]** and are in need of our services. It is our obligation as a program to make sure we are providing the best services possible.

The child client feedback form is one method for us to receive feedback from the children and families we serve. The responses should help us to improve our services and better meet the needs of our clients. This is in no way to evaluate individual staff members and should not be used as a tool to evaluate staff. In addition to our own services, this tool should help us look at the services received by other service providers in order to improve our efforts to strengthen the services provided by partners.

The child client feedback forms should be completed through an interview with the child survivor and his/her caregiver if appropriate (see the guidelines on the child consent form). With the permission of the survivor, **[insert who]** will conduct the interview. Please inform the survivor that no questions about her case will be asked during the questionnaire and it is just to get information on the services she or he received and that all responses will be kept confidential. If the child/caregiver is able to read and write and would like to complete the form on her/his own, this is also acceptable. Make sure to still inform the child that the information she writes on the form will be confidential.

As usual, the needs of the child client should always be considered first and the decision to administer the child client feedback form should be determined on a case to case basis. If the caseworker and officer feel that administering the questionnaire would harm the child client or impact their treatment, the questionnaire should not be administered. As always, the most important principle to follow is to not cause any further harm to the child survivor.

INSTRUCTIONS: Child Client Feedback Steps

Step 1: [insert person/position] providing treatment to ask permission from the child client and/or his or her caregiver. Steps for obtaining consent are:

1. If the child is 9 years old or younger, and the caregiver was **actively and positively involved** in the child's care and treatment, the caseworker should obtain consent for the Satisfaction Questionnaire from the caregiver and interview the caregiver only.
2. If the child is between the ages of 10-12 years old, and the caregiver was **actively and positively involved** in the child's care and treatment, the caseworker should obtain consent from the caregiver and interview the caregiver directly. However, children at this age should also be asked for their opinion about the care they received, and if appropriate, can be included in the interview with the caregiver, or interviewed separately. This should be decided on a case by case basis by the [insert person/position].
3. If the child is 14 years and older (14-18), consent for conducting the Satisfaction Questionnaire can be obtained from the child client directly, and the child can be interviewed directly about his/her satisfaction with services provided. If appropriate, the [insert person/position] may also want to conduct a separate interview with the child's caregiver, if they were actively and positively involved in the child's care and treatment. It is required to get the permission from the child survivor FIRST, before approaching the child's caregiver.

Sample Script: "We would like to know how you feel about the case management and counseling services the [insert agency] has provided to you [or your child/family]. We would like to ask you a few questions about the services you received from us. These questions help us to improve our services. Your responses will remain completely anonymous and will not affect your care in any way. Do you agree to speak with the [insert name/position] about the services you received? (Yes/No)"

Step 2: Message from the [insert name/position]

- Inform the client(s) that you will ask her/him some questions, but will not write their name on the form and that the interview will remain anonymous
- Remind the client(s) that this will help the [insert agency] provide survivors with better services
- Remind the client(s) that you will not be asking her/him any questions about his/her actual case, but are just interested in the services received throughout case management (if the survivor wants psychosocial support from the [insert name/position] this should not be denied, but the client information should be given to the caseworker separately from this client feedback form)

Sample Child Client Questionnaire Feedback Form

Step 3: Administer Client feedback form/questionnaire

You do not have to participate in the questionnaire but your responses will help us ensure that we provide the best possible services. Will you agree to answer the following questions about the services you received? (Yes / No)

1. How did you find out about the [insert agency name] services (tick all that apply)?

➤ *List out all possibilities here.*

2. Did you ever try to visit the counseling center and find there were no caseworkers present?

2.1 No

2.2 Yes, explain:

3. What kind of assistance were you expecting from [insert program] (tick all that apply)?

➤ *See sample options below – list specific possibilities*

3.1 Counseling /psychosocial support

3.2 Case management

3.3 Assistance going to [health or safety or legal or other service providers]

3.4 Material assistance

4.8 Other: (Resettlement, Shelter)

4. Were your expectations met?

4.1 Yes

4.2 Somewhat, explain:

4.3 No, explain:

5. Were you treated in a respectful way by the [staff person – e.g. caseworker]?

5.1 Yes

5.2 No, explain:

6. Did the [staff person – e.g. caseworker] make you feel comfortable to share your experiences and ask for help?

6.1 Yes

6.2 No, explain:

Sample Child Client Questionnaire Feedback Form

7. For children only: Did **[staff person – e.g. caseworker]** communicate with you in a way that you understood?

8.1. Yes

8.2. No, explain

8. Did you feel like the **[staff person – e.g. caseworker]** blamed you in any way for what happened?

9.1. Yes

9.2. No, explain

9. Did you feel like the **[staff person – eg.s. caseworker]** believed what you told her?

9.1 Yes

9.2 No, explain:

10. Did you get information that was helpful to you?

10.1 Yes

10.2 Somewhat, explain:

10.3 No, explain:

11. Did you feel pressured by any **[staff person – eg.s. caseworker]** at any time to make a decision or do something that you did not wish to?

11.1 Yes, explain:

11.2 No:

12. Did the **[staff person – e.g. caseworker]** refer you to any other services?

12.1 No, because:

12.1.1 Did not need to access other services

12.1.2 Did not want to access other services

12.1.3 Other (specify):

12.2 Yes

➤ *List services providers here.*

13. Did the **[staff person – e.g. caseworker]** follow-up and do what was agreed?

13.1 Yes

13.2 No, explain:

Sample Child Client Questionnaire Feedback Form

14. Do you feel like **[insert agency]** helped you with your problem?

14.1 Yes

14.2 Somewhat, explain:

14.3 No, explain:

15. Do you feel like **[insert agency]** helped you address problems in your family related to the abuse?

15.1 Yes

15.2 No, explain:

16. In general, did you feel better after meeting with us **[insert name agency]**.

16.1 Yes

16.2 No, explain:

15. Do you have any additional feedback or concerns about how the **[insert agency]** program can improve our work with other children and/or families?

Thank you for taking the time to take this questionnaire, we hope that the responses to these questions and your honest feedback will help us improve our services.

Supervision Tool

Caring for Child Survivors Case Management Assessment (CCS-CMA)

Date:

Staff Name:

Supervisor:

Instructions for Administering the Tool

PURPOSE

This assessment represents the minimum standards of child sexual abuse case management competencies required for health and social work staff working directly with child survivors of sexual abuse. Competent care rests on service providers knowing how to provide child-centered case management. This is a staff supervision tool for managers/supervisors to use periodically with staff providing care directly to children and families.

INTRODUCTIONS

- (1) This supervision tool should be performed through a verbal interview between the staff and his/her supervisor in a quiet and confidential location.
- (2) The supervisor should inform the staff person this tool is being used to assess areas where further capacity building is needed. It is not a performance evaluation tool. The supervisor should explain they will receive a score to determine if individual staff member 'meets' the overall case management competency assessment.
- (3) The supervisor asks the staff person to explain/describe the concepts below and score accordingly:
 - **Met:** If the individual is able to answer the questions correctly and fully, they will receive a mark of 'met'.
 - **Partially Met:** If the individual is able to answer **at least 50%** of the question, they will receive a mark of partially met. For example, if the question is, "name the guiding principles for working with child survivors" and the person can only name 4, they will receive a 'partially met' score.
 - **Unmet:** If the individual is unable to answer the question, they will receive a mark of 'unmet'.
- (4) Once the assessment is complete, the supervisor will score the assessment and discuss with the staff member his/her scores, what they mean, and any further capacity building needed

Administering the Tool

Case Workers Providing Case Management and/or Psychosocial Services have already Met these Competency Assessments	Yes	No	Not Evaluated
Demonstrate in-depth knowledge about child sexual abuse (as evidenced by the CCS - KA)			
Demonstrate child friendly attitudes and beliefs (as evidenced by the CCS Attitude Scale)			
Demonstrate child friendly attitudes and beliefs (as evidenced by the CCS - CA)			

Case Management Skills	Criteria for Answering Correctly	Met 2 pts	Partially Met, 1 pt	Not Met 0 pts
1. What are the Guiding Principles for Working with Child Survivors	Need to list all guiding principles for full (100%) score. Need to list at least 4 principles for half score (50%) score: 1. Promote the Child's Best Interests 2. Ensure the safety of the child 3. Provide Comfort & Reassurance 4. Maintain Appropriate Confidentiality 5. Involve the Child in Decision-Making 6. Treat Every Child Fairly & Equally 7. Strengthen Children's Resiliencies			
2. What are the mandatory reporting requirements in this setting?	1. Needs to be developed locally.			

3. What are the limits to confidentiality in child cases?	Need to explain the three main limits for full score:	<ol style="list-style-type: none"> 1. If there are mandatory reporting laws in place 2. The need to protect a child's physical and/or emotional safety 3. Need to obtain parental consent if a young child presents for services (and there is no risk in doing so) 4. If a child is at risk of harming another person (possibly homicidal) 			
4. Explain how informed consent/assent procedures are adapted with children.	Should include these key points for full score:	<ol style="list-style-type: none"> 1. Based on the child's age and developmental stage 2. Based on the presence/absence of supportive caregivers 			
5. What are the three case actions that promote a child's best interest?	Should include all the following points for full score:	<ol style="list-style-type: none"> 1. Protect the child from potential or further emotional, psychological and/or physical harm. 2. Reflect the child's wants and needs. 3. Empower children and families. 4. Examine and balance benefits and potentially harmful consequences. 			
6. When is informed consent/assent sought during case management?	Need to state both times to get full score:	<ol style="list-style-type: none"> 1. At the start of case management services 2. For referrals to other services provides This includes obtaining permission for collecting data (IMS) and using it in statistical reports			
7. Explain the main areas of need that you need to asses for a child survivor	Should name at least four assessment areas for full credit:	<ol style="list-style-type: none"> 1. Safety and protection 2. Medical care and treatment 3. Psychosocial needs 4. Legal/justice needs 			
8. What are the steps of case management?	Need to name all 7 steps for full credit (4 steps for 50% - partially met)	<ol style="list-style-type: none"> 1. Introduction and engagement 2. Intake and assessment (interview) 3. Case action planning 4. Implementing the case action plan. 5. Follow up and monitoring 6. Case Closure 7. Case Management Service Evaluation 			
9. What are the steps for assessment if a child is expressing feelings of suicide?	Need to name all 4 steps for full credit (2 for 50% - partially met)	<ol style="list-style-type: none"> 1. Step 1: Assess current/past suicidal thoughts 2. Step 2: Assess risk: lethality and safety needs 3. Step 3: Address feelings and provide support 4. Step 4: Formulate a safety action plan. 			
10. What are the main criteria for knowing when to close a case.	Need to name all 3 criteria for full credit (2 steps for 50% - partially met)	<ol style="list-style-type: none"> 1. The case plan is complete and satisfactory, and follow-up is finished. 2. There has been no client contact for a specified period (e.g., more than 30 days). 3. The child client and caseworker agree that no further support is needed. 			

Supervision Tool

CCS Case Management Checklist

INSTRUCTIONS

The Case Management Supervisor should use this checklist as part of case supervision, within two weeks of a caseworker responding to a case of child sexual abuse. The Supervisor should review the caseworker's practice on an individual case, by asking the caseworker if she or he completed the tasks listed for each step of case management. This checklist reviews provides an opportunity to evaluate the caseworkers direct practice and to receive supervision from his or her case manager/supervisor.

CREATE A CLIMATE OF TRUST, SUPPORT AND CARE

Did the case worker...	Yes	No	N/A	Supervisor Comment
1. Stay calm and comforting throughout the child's care and treatment				
2. Communicate with the child using simple, clear, non blaming language				
3. Tell the child she is strong and brave to tell her what happened, that telling is the right thing to do				
4. Tell the child it is not her fault and that she is not to blame for what happened.				
5. Appropriately include the child's ideas, views and opinions throughout her care and treatment.				
6. Not overwhelm the child with too much information. Help the child prioritize his or her needs.				
7. Establish a positive relationship with the child's non-offending caregivers/parents (if possible).				

INTRODUCTION/ENGAGEMENT & INTAKE AND ASSESSMENT STEPS

Did the case worker...	Yes	No	N/A	Supervisor Comment
1. Explain to the child in simple, clear terms about case management services and confidentiality				
2. Obtain informed consent and informed assent from the child and/or caregiver appropriately.				
3. Conduct a safe and supportive interview (following the best practices for communication/interviewing).				
4. Collect only the details of the incident relevant to helping the child and his/her family?				
5. Assess the child's safety, health, psychosocial and legal/justice needs appropriately.				
6. Complete the correct forms and documentation				

CASE ACTION PLANNING & IMPLEMENTING THE ACTION PLAN STEPS

Did the case worker...	Yes	No	N/A	Supervisor Comment
1. Develop treatment goals and an action plan based on the assessment of needs.				
2. Involve the child's views and opinions in decision-making according to best practice.				
3. Involve the caregiver in the child's care and treatment action plan.				
4. Ensure the child's best interests (e.g.: making sure any actions taken will safeguard physical and emotional safety) when planning action steps.				

3. What are the limits to confidentiality in child cases?	Need to explain the three main limits for full score:	<ol style="list-style-type: none"> 1. If there are mandatory reporting laws in place 2. The need to protect a child's physical and/or emotional safety 3. Need to obtain parental consent if a young child presents for services (and there is no risk in doing so) 4. If a child is at risk of harming another person (possibly homicidal) 			
4. Explain how informed consent/assent procedures are adapted with children.	Should include these key points for full score:	<ol style="list-style-type: none"> 1. Based on the child's age and developmental stage 2. Based on the presence/absence of supportive caregivers 			
5. What are the three case actions that promote a child's best interest?	Should include all the following points for full score:	<ol style="list-style-type: none"> 1. Protect the child from potential or further emotional, psychological and/or physical harm. 2. Reflect the child's wants and needs. 3. Empower children and families. 4. Examine and balance benefits and potentially harmful consequences. 			
6. When is informed consent/assent sought during case management?	Need to state both times to get full score:	<ol style="list-style-type: none"> 1. At the start of case management services 2. For referrals to other services provides This includes obtaining permission for collecting data (IMS) and using it in statistical reports			
7. Explain the main areas of need that you need to assess for a child survivor	Should name at least four assessment areas for full credit:	<ol style="list-style-type: none"> 1. Safety and protection 2. Medical care and treatment 3. Psychosocial needs 4. Legal/justice needs 			
8. What are the steps of case management?	Need to name all 7 steps for full credit (4 steps for 50% - partially met)	<ol style="list-style-type: none"> 1. Introduction and engagement 2. Intake and assessment (interview) 3. Case action planning 4. Implementing the case action plan. 5. Follow up and monitoring 6. Case Closure 7. Case Management Service Evaluation 			
9. What are the steps for assessment if a child is expressing feelings of suicide?	Need to name all 4 steps for full credit (2 for 50% - partially met)	<ol style="list-style-type: none"> 1. Step 1: Assess current/past suicidal thoughts 2. Step 2: Assess risk: lethality and safety needs 3. Step 3: Address feelings and provide support 4. Step 4: Formulate a safety action plan. 			
10. What are the main criteria for knowing when to close a case.	Need to name all 3 criteria for full credit (2 steps for 50% - partially met)	<ol style="list-style-type: none"> 1. The case plan is complete and satisfactory, and follow-up is finished. 2. There has been no client contact for a specified period (e.g., more than 30 days). 3. The child client and caseworker agree that no further support is needed. 			



Chapter Six

PSYCHOSOCIAL INTERVENTIONS FOR CHILD SURVIVORS

This chapter is for service providers providing case management and/or psychosocial services.

CONTENTS OF THIS CHAPTER INCLUDE

- » Guidelines for conducting a child and family psychosocial needs assessment
- » Guidelines for implementing psychosocial interventions for children and families

TOOLS IN THIS CHAPTER INCLUDE

- » Child and Family Psychosocial Needs Assessment Tool
- » Guidelines for Implementing Core Psychosocial Interventions
 - Healing Education for Children and/or Caregivers
 - Relaxation Training
 - Coping Skills Identification
 - Problem Solving

CHAPTER OVERVIEW

This chapter details how to conduct a more in-depth psychosocial assessment for children and families using the Child and Family Psychosocial Assessment tool, and outlines a set of direct psychosocial interventions that can be offered to children and families affected by sexual abuse.⁷³

⁷³ Direct psychosocial interventions refer to “person-focused” interventions. This means the caseworker directly works with the child and/or family client to improve their functioning and well-being. Community based (e.g., referrals to child friendly centers) are not covered in this chapter.

INTEGRATING PSYCHOSOCIAL INTERVENTIONS INTO A CHILD AND FAMILY'S CARE AND TREATMENT

The psychosocial interventions described in this chapter are meant to be provided directly to the child (and family members as appropriate) and aim to help child survivors:

1. understand and manage reactions to the abuse;
2. develop skills for managing anxiety and stress;
3. learn new skills for coping with negative reactions, and;
4. acquire new skills for solving problems.

Some children experience more severe mental health problems as a result of sexual abuse and yet, mental health services are limited in humanitarian settings. This chapter does not provide instruction for how to deliver child mental health services for survivors of sexual abuse. However, the set of four psychosocial interventions described in this chapter can be used as a starting point to help children recover and contribute to their own healing in low-resource settings.⁷⁴

⁷⁴ The psychosocial interventions presented in this chapter do not constitute a complete mental health intervention for children suffering from posttraumatic stress disorder, depression or other serious mental health diagnoses.

ASSESSING THE PSYCHOSOCIAL NEEDS OF CHILD SURVIVORS

As discussed in Chapter 5, sexually abused children generally have needs that fall into four categories: safety, health care, psychosocial support and justice/legal services. The standard case management approach focuses on the initial intake and assessment process to pinpoint these needs and on mobilizing intervention support to meet the most immediate needs. From there, caseworkers follow the steps of case management (developing and implementing the action plan, follow-up, and so on) until the child's state of security and well-being has been established.

For case management agencies that offer or would like to offer a set of psychosocial interventions to accompany standard case management, agencies can use a more comprehensive assessment tool to better understand the child's social and family environment, psychological well-being, and strengths to help determine appropriate psychosocial interventions. Caseworkers can integrate the additional psychosocial assessment into the child's care—likely during the “implement actions” step of case management—or when it is most appropriate to do so.

A psychosocial assessment in child sexual abuse cases requires that caseworkers evaluate broader areas and needs of the child and the child's family environment,⁷⁵ in addition to possibly gathering additional information about the abuse incident itself. Ideally, children are evaluated within the larger context of their family and community, as these factors always play a key role in the child's care and treatment plan and determine support for overall recovery. Below, a sample psychosocial assessment tool is introduced, along with instructions for caseworkers who can apply this tool to support a more complete psychosocial assessment of child survivors.

REMEMBER

An additional, and more specific, psychosocial assessment takes place only after the child's immediate health and safety needs have been addressed.

⁷⁵ Family is defined as a social system in which connected people interact with each other in an organized, predictable way. The process of defining family varies across cultures and should be adapted accordingly.

KEY CONSIDERATIONS FOR CASEWORKERS BEFORE CONDUCTING THE PSYCHOSOCIAL ASSESSMENT

INVOLVING CAREGIVERS AND OTHER THIRD-PARTY SOURCES IN THE CHILD'S ASSESSMENT

Assessing children and family members affected by sexual abuse requires that information be gathered from the child, the non-offending caregivers and other trusted sources close to the child, as decided and determined by the child and caseworker. An important decision for caseworkers is whether—and how—to involve children's caregivers or other trusted adults, such as teachers, in any interview with a child. Analyzing who, if anyone, is best suited to participate in the child and family assessment depends on specific information likely to have been discovered during the initial stages of case management. For example, a caseworker might consider the presence of:

- » A supportive, non-offending caregiver/parent.
- » The person who referred the child for services, taking into consideration the person's relationship with the child.
- » People identified by the child directly as trusting adults in the child's life, or people who spend significant time with the child.

As a general rule, psychosocial assessments can be conducted with children ages eight and above. Caseworkers must determine the capacity of children to participate on a case-by-case basis, taking into account their capacity to understand what is happening and their willingness to participate. Assessments involving children should ideally include information from other relevant people in the child's life, including parents, caregivers, siblings, neighbors and teachers. In order to talk with other people in the child's life, however, caseworkers must first discuss—and gain permission—from the child. As a general principle, caseworkers should include non-offending parents/caregivers in the child's treatment immediately, right from the very start of services, if appropriate. However, following the standard guidelines, caseworkers should not involve a parent/caregiver in the child's care and treatment if:

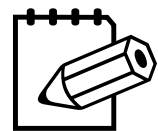
- » The caregiver is the suspected/actual child abuser.
- » The child does not want the caregiver included in the interview.
- » The caseworker feels that the child cannot or will not speak freely.

DEVELOPING AN ASSESSMENT STRATEGY

Before starting the assessment interviews, caseworkers should think through an assessment strategy. This includes considering:

- » How to structure the assessment (number of interviews, types of communication techniques, such as verbal and non-verbal games and activities, etc.).
- » Who to include in the assessment (caregivers, parents, or other trusted adults).

CONDUCTING THE ASSESSMENT: USING THE CHILD AND FAMILY PSYCHOSOCIAL ASSESSMENT TOOL



The Child and Family Psychosocial Assessment helps caseworkers follow a systematic process for assessing children's and family's psychosocial needs. Structured psychosocial assessments provide caseworkers with a more complete picture of a child's family, home, community, school and individual context to better direct psychosocial support. The Child and Family Psychosocial Assessment Tool guides the caseworker to understand the child's situation in regard to:

- » Home and social contexts, including an assessment of the parent/child relationship.
- » Day-to-day well-being and functioning.
- » Caregivers' feelings and beliefs toward the child and sexual abuse.
- » Child and family strengths.
- » Opportunity to assess further safety issues (as part of ongoing intervention).

full tool at end of chapter

Survivor Code: <input style="width: 90%;" type="text"/>	Incident ID: <input style="width: 90%;" type="text"/>	
Child and Family Psychosocial Assessment		
Caseworker code	Date	Time
Part II: Main Problems/Worries		
<p><small>For this section, case workers should use questions and/or drawing activities with children get a sense of what their main problems and concerns are following the experience of abuse. In this box, case workers should write down the current status of the child based on his or her own words.</small></p> 		
PART III: Family, Social & Spiritual Context		
<p><small>Family & Living Situation: Guidance for assessment: where does the child live (sleeps, eats, hangs around); who lives in the house and visits frequently; number of siblings, does the child appear happy in the home? Is the child able to play freely and where? Does the child appear afraid and/or not close to with parents/guardians, siblings; Is the child treated differently to other children in the family?</small></p> 		
Social Support (friendships, school, participation in social and community life)	Spiritual/religious:	
Other Notes: (e.g. safety risks identified, etc)		
1		

USING THE CHILD AND FAMILY PSYCHOSOCIAL ASSESSMENT TOOL

The first step is filling out the administrative section (see pg 225 for full tool), which includes writing on the form the survivor's unique code and the incident number, which is developed from the agency's practice of assigning individual survivors with unique codes. In addition, the caseworker writes in their own personal caseworker code, the date and time of the assessment. Sometimes conducting a full assessment requires more than one meeting with a child. In this situation, the caseworker can record more than one date on the form.

Child and Family Psychosocial Assessment		
Caseworker code	Date	Time

ASSESSMENT AREA II: MAIN PROBLEMS OR WORRIES (FROM THE CHILD/CAREGIVER)

When conducting interviews with children, it can be helpful for caseworkers to use open-ended questions and ask them for their own perspectives on their lives. This allows children to share whatever is on their minds, rather than immediately asking them about specific aspects of their lives. Children should always feel they can share anything they want and on their own terms. Caseworkers need to assess all data that can help them understand what their child clients perceive to be the main worries or problems in their lives at any given moment.

To effectively dialogue with children in a way which will help them express themselves, caseworkers should draw upon the verbal and non-verbal techniques described in Chapter 3. For example, if the caseworker wants to know how the child is feeling or what the child's main worries are, he/she may want to ask the child to draw a picture to illustrate those feelings or worries. The caseworker can also ask the child to draw a picture of what a typical day looks like. It is important, however, that caseworkers always discuss these drawings with children to avoid inaccurate interpretations.

Caseworkers may want to find out from caregivers what they perceive as the main problems/concerns regarding their case/situation. If possible, assessing the child's main concerns/worries and assessing the caregiver's main concerns/worries should be done separately so both child and caregiver are able to share freely with the caseworker. In instances where the caseworker does not see a need to separate the child and caregiver, their perceptions can be assessed together. Caseworkers will want to pay close attention to whether the child's and caregiver's main concerns/worries are the same or different. If the concerns/worries are different, the

caseworker should discuss the child's concerns with the caregiver to promote communication and understanding between the child and caregiver.

The caseworker records what the child says during these conversations. In particular, the caseworker will focus on worries, problems and other current issues that the child raises. See the diagram below from the Child and Family Psychosocial Assessment form.

Part II: Main Problems/Worries

For this section, case workers should use questions and/or drawing activities with children get a sense of what their main problems and concerns are following the experience of abuse. In this box, case workers should write down the current status of the child based on his or her own words.

ASSESSMENT AREA III: FAMILY, SOCIAL AND SPIRITUAL CONTEXT

Gathering data on the child's family, social and spiritual situations and beliefs is important to understanding the broader context around the child. Children do not live in a vacuum; understanding their family and community environments is necessary to facilitate healing and recovery. Caseworkers should consider the following guidelines for assessing these areas of children's lives:

Family and Living Situation: The caseworker may already know where the child is living and with whom the child is living based on information gathered during the intake and initial assessment sessions. For the psychosocial assessment, caseworkers should focus on gathering specific data about a child's living situation (where does the child eat and sleep, how many people live in the home, etc.), as well as the child's "lived experience." For example:

- » Who did the child trust the most in the family before the abuse happened? Who does the child trust after the abuse? Is the child happy at home? Does the child have basic needs met (food, clothing, education, protection)? Is the child treated differently from other children in the family? Is the child able to play freely?

This information helps the caseworker better understand the child in his/her family context, thus enabling the caseworker to direct psychosocial support.

6 PSYCHOSOCIAL INTERVENTIONS FOR CHILD SURVIVORS

Social/Spiritual Support: A child's social support, which may include family members, is a key area for assessment. Children recover from sexual abuse best when they have social support and are able to resume activities that are developmentally appropriate. Caseworkers should identify, strengthen and build upon areas where children's social support has diminished (lack of friends, failure to attend school, etc.). Caseworkers should also assess children's religious and spiritual beliefs/practices, including the possibility of identifying influential religious teachers or leaders to play a role in the child's recovery.

Based on the information gathered in this section, the caseworker records important details and facts in **Part III: Family, Social and Spiritual Context**, of the assessment tool. In addition, in the section **Other Notes**, the caseworker can record additional details that are important but not specific to the family, social and spiritual contexts.

PART III: Family, Social & Spiritual Context

Family & Living Situation: *Guidance for assessment: where does the child live (sleeps, eats, hangs around); who lives in the house and visits frequently; number of siblings, does the child appear happy in the home? Is the child able to play freely and where? Does the child appear afraid and/or not close to with parents/guardians, siblings; Is the child treated differently to other children in the family?*

Social Support *(friendships, school, participation in social and community life)*

Spiritual/religious:

Other Notes: *(e.g. safety risks identified, etc)*

ASSESSMENT AREA IV: OVERALL FUNCTIONING ASSESSMENT

Most children know sexual abuse is wrong. They usually have feelings of fear, shock, anger and disgust. However, a small number of abused children may not realize sexual abuse is wrong. These children might be very young or have mental challenges.

Children who have been sexually abused often show signs of emotional and psychological distress. Children may behave in nervous or upset ways. Children may have bad dreams. Children may appear anxious and worried. Children, especially boys, might “act out” with behavior problems, for example, fighting more often with people. Other children “act in” by becoming

depressed. They may withdraw from friends or family. Older children or teens might try to hurt or even kill themselves.

Conducting a basic assessment of children's functioning (by looking at children's behaviors, feelings and expressions of somatic or "physical" complaints) helps the caseworker identify changes that may have occurred since the instance of sexual abuse and/or disclosure.

PART IV: Child Functioning Assessment			
DIRECTIONS: The caseworker should ask the child survivor these questions in a private, confidential room. Say: I'm going to read some sentences. Please tell me how TRUE these sentences are about you. Think about how true these things are since _____ [describe abusive event...e.g., you were raped]			
<i>There can only be the X mark in one column.</i>	YES	NO	COMMENTS
1. I don't see my friends as much as I used to.			
2. I have stopped my daily activity (e.g. school).			
3. I am having fights with people more than I used to.			
4. I am having a hard time going to sleep or staying asleep.			
5. I am having body aches, stomachache, headache or other aches.			
6. I worry that something bad is going to happen.			
7. I am feeling sad and hopeless.			

ASSESSMENT AREA V: CAREGIVERS'/PARENTS' FEELINGS AND BELIEFS

If possible, caseworkers should assess caregivers' feelings, beliefs and perceptions about their child's sexual abuse. Understanding the caregivers' perspectives provides insight into the support (or lack of support) they are providing and/or can provide to their child. It is extremely important for caseworkers to assess accurately how caregivers behave toward the child, based on their perceptions and beliefs surrounding the abuse, as this will be an important part of the overall child and family treatment planning.

Assessing caregivers' perceptions requires special precautions to ensure child survivors are not inadvertently exposed to negative feelings or perceptions. For example, it is possible that caregivers blame their child or say negative things during this part of the assessment. Therefore, the caseworker should assess caregivers in private (not in front of the child). This allows the

6 PSYCHOSOCIAL INTERVENTIONS FOR CHILD SURVIVORS

parents/caregivers to share freely their concerns, in a space that is private and safe. The child should be told why their caregivers are being interviewed separately.

Caseworkers should ask the caregivers a series of questions and also allow them to share their views, opinions and/or questions freely. The questions should focus on the caregivers' perceptions and how they relate to the child. The key questions are:

- » **What is your understanding of the abuse/what happened?** This question helps the caseworker understand how much the caregiver knows and understands about what happened. The caseworker should watch out for statements of blame directed toward the child.
- » **What are your feelings about the abuse/situation?** This question explicitly asks caregivers what their feelings are about the sexual abuse. Here the caseworker should attempt to evaluate the caregivers' own level of emotional distress and their feelings toward their child. Caseworkers should ask whether caregivers' feelings have changed toward their child since the abuse.
- » **What changes have you noticed in your child since the abuse?** Oftentimes, reports of children's emotional distress come from adults in the child's life who notice behavior changes. This question also provides caseworkers with more information about the caregivers' perspectives on their child.
- » **What do you think will help your child right now?** Identifying what caregivers think is useful and important to help their children heal and recover. Supportive caregivers know their children well and their ideas about how to support their children's healing should be asked and integrated into psychosocial care plans.
- » **What are your main worries and needs right now?** This question provides an opportunity for caregivers to share their personal worries and fears while alerting the caseworker to additional needs/worries that may impact the child.

Based on the information gathered in this section, the caseworker records answers in the "comments/responses" box in Part V: Caregiver Assessment of the tool. If the caregiver does not answer a question, the caseworker can write "cannot assess," with an explanation.

PART V: Caregiver Assessment (if possible)	
What is your understanding about the abuse and what happened?	
What are your feelings about the abuse and what happened?	
What changes have you noticed with your child since the abuse?	
What do you think will help your child right now?	
What are your main worries and needs right now?	

ASSESSMENT AREA VI: CHILD AND FAMILY STRENGTHS (ALSO CALLED ‘RESILIENCIES’)

Children and families are resilient. The majority of abused children will cope and recover with good care and support. Children's strengths or “resiliencies” support their natural capacity to heal from difficult experiences. It is the job of caseworkers to help children identify their strong points and identify aspects of life that fill them with hope.

HOW TO ASSESS CHILDREN'S STRENGTHS

Caseworkers should help children identify their own strengths, such as:

- » **Their courage.** Children are strong and brave for telling other people their stories of abuse. Caseworkers should emphasize this and ask children for other examples of facing their fears. Additional examples provide more concrete data for children to recognize their bravery.
- » **Their positive personality characteristics.** Perhaps a child is funny, smart, talkative, curious, polite or shows other positive characteristics. Caseworkers should talk with children about ways they can use humor/intellect/curiosity to excel in school and life in general.
- » **Their pride.** Asking children what they are proud of or what makes them feel good helps to identify inner or unrecognized strengths (such as attending school, being able to make a dress, etc.). Questions such as, “With all that has happened, what makes you smile, even just a

RESILIENCIES ARE

the mechanisms that help individuals, families and communities endure and recover from adversities. Resilience results from individual characteristics, coping mechanisms (innate and acquired) and the protective factors in a child or youth's environment.

little?" can help children identify aspects of their lives that give them hope. If a child cannot identify a strength or area of pride, the caseworker should reinforce those he/she has identified in the child.

HOW TO ASSESS CAREGIVER/FAMILY STRENGTHS

Caseworkers can also identify strengths of caregivers/family during the assessment process. Caregiver strengths include, but are not limited to, the following:

- » Supporting their child.
- » Advocating for their child's care.
- » Protecting their child and reaching out to caseworkers.
- » Handling family problems.
- » Encouraging hopes and dreams.

Child sexual abuse has an impact on caregivers as well. Caregivers may feel upset, scared, or guilty because they could not protect their child. It is important for caseworkers to help caregivers identify their own strengths and explore examples where they did the right thing. Areas for caseworkers to assess are:

- » **Attachment to child.** A strong and positive attachment to their child is a very important family strength. Strong and supportive attachments between caregivers and the child are vital to the child's healing from sexual-abuse-related trauma.
- » **Family capacities, hopes and dreams.** Learning how caregivers traditionally solve problems, and what their hopes, dreams and other capacities are (such as friends, faith, nonviolent home, etc.) can help caseworkers pinpoint positive traits to include in the child's psychosocial support action plan.
- » **Social support.** The family's connectedness to their community and social support network are important strengths.
- » **Jobs and financial assets.** Having a job and income and using family money appropriately are also important strengths.

Child Strengths/Protective Factors (things the child enjoys going, positive relationships to caregivers, people they trust and who support them, able to solve problems, feel hopeful, laugh, etc)	Caregiver & Family Strengths/Protective Factors (strong and positive relationship with their child, other family members; able to cope with stress; social and community support; job/income)



Photo: Aubrey Wade/the IRC

CHILD AND FAMILY PSYCHOSOCIAL EVALUATION AND INTERVENTION PLANNING

In many settings, more advanced psychosocial and mental health services will not be available to address the specific emotional and psychological distress that many children and families experience following the disclosure of sexual abuse. Despite this, there are common and effective interventions that caseworkers can provide to help children with the psychosocial difficulties discovered during the assessment process.

Following the assessment interview, the caseworker will analyze the information and choose psychosocial interventions as described below, based on the main problems identified. Staff should be trained to provide basic yet effective psychosocial interventions for child survivors, and build these interventions into existing case management and psychosocial care delivery.

Most of these interventions will happen with children in one-on-one sessions. One-on-one sessions between a caseworker and child survivor provide children with structure (for example, they meet their caseworker each week) and a safe space to express their feelings related to the abuse. They allow children a chance to begin to process traumatic events.

If children present no psychosocial problems or needs, they should be offered the opportunity to participate in education sessions that help them learn relaxation techniques and other skills.

SET OF CORE PSYCHOSOCIAL INTERVENTIONS FOR SEXUAL ABUSE

The following psychosocial interventions can be applied in cases of child sexual abuse. In addition, healing education and relaxation training can be helpful for child clients even if they do not express psychosocial difficulties following sexual abuse. The psychosocial interventions include:

INTERVENTION 1: PROVIDING HEALING EDUCATION

Providing children and families with accurate information about sexual abuse helps them understand and manage the impact of abuse. The intervention aims to:

- a. Provide children and caregivers with an accurate understanding of sexual abuse and its associated impacts.
- b. Ensure that children and caregivers can identify signs and symptoms of trauma.

INTERVENTION 2: RELAXATION TRAINING

Children often experience anxiety and/or psychosomatic complaints (racing heart, sweating, shaking) that result from anxiety and stress. Teaching skills for managing anxiety can help children feel more in control of their bodies and calm their minds. This intervention aims to:

- a. Ensure that children and caregivers sleep and eat regularly.
- b. Ensure that children and caregivers manage stress-related symptoms on their own.

INTERVENTION 3: TEACHING COPING SKILLS

Children may have negative feelings after sexual abuse. Coping skills help children learn to help themselves. This intervention aims to:

- a. Help children recognize their feelings, positive and negative.
- b. Help children increase their capacity to cope with difficult emotions.

INTERVENTION 4: PROBLEM SOLVING

Children have ideas and knowledge about how to solve their problems. Caseworkers can help children develop “problem solving plans” to address their main problems. This intervention aims to:

- a. Teach children and caregivers to identify everyday problems.
- b. Empower children and caregivers to think through solutions to their day-to-day problems.

Evaluating the Assessment: Developing the Psychosocial Action Plan

Once the psychosocial assessment is complete, the caseworker evaluates the information gathered using **Part VII: Psychosocial Assessment and Action Plan** of the Child and Family Psychosocial Assessment Tool (see below).

The main assessment areas are described at left side on the table on the following page. The outcome (yes/no) will help the caseworker determine which psychosocial interventions are appropriate.

Note: Specific directions on carrying out the individual interventions (e.g., problem solving, healing education, relaxation training and coping skills) are described in-depth in the next section.

PART VII: Psychosocial Evaluation & Action Planning (for the caseworker to complete only)				
Assessment Questions	Yes	No	N/A	Action Plan for Intervention (include, what is the action, who is responsible and timeframe)
1. Did the child report having problems functioning (See functioning items 1-3). If yes: interventions required: 1. Problem solving 2. Healing education 3. Relaxation training				
2. Did the child report feeling anxious or worried (See Functioning items 4-6). If yes: interventions required: 1. Relaxation training 2. Healing education Problem solving (if needed)				
3. Did the child report having negative feelings (See Functioning items 7-8). If yes: interventions required: 1. 3-Step Coping 2. Healing education 3. Relaxation training				

In addition, the caseworker will document the child and family strengths identified during the assessment and describe how these strengths can be brought into the child's psychosocial care plan.

List the strengths (child and family) that can support the child's healing. (school, activities, sense of humor, etc).
--

6 PSYCHOSOCIAL INTERVENTIONS FOR CHILD SURVIVORS

Lastly, the caseworker will list additional areas (e.g., child's legal status, family economic issues, school and housing situation) that require intervention either in the form of a referral or through direct action by the caseworker, child and/or caregiver.

Other areas of need identified during the assessment that require intervention (direct and/or referral)
(if not addressed above)

Identified Need:

Action Plan (include what action, who will do what, and timeframe).

When the assessment and psychosocial support plan is in place, the caseworker, child client, and caregiver (if needed) must schedule the appropriate follow-up appointments.

Next Follow Up Appointment scheduled for (date/time)_____

CHILD AND FAMILY PSYCHOSOCIAL ASSESSMENT CHECKLIST

In cases of child sexual abuse, have the following areas been assessed?

- ☐ Child's expression of needs/problems.
- ☐ Family, social and spiritual context.
- ☐ Child functioning assessment.
- ☐ Caregiver's beliefs/perceptions.
- ☐ Child and family strengths.
- ☐ Additional concerns (safety or other).

The evaluation and intervention planning takes place after the assessment.

HELPFUL TIP

Caseworkers should always remain alert to possible safety risks and concerns that emerge during assessment interviews. Safety issues should be a priority in the child's case action plan.



GUIDELINES FOR IMPLEMENTING CORE PSYCHOSOCIAL INTERVENTIONS

Please note: Staff providing psychosocial interventions with children affected by sexual abuse must first be trained in child sexual abuse case management and communication techniques.

INTERVENTION 1: CHILD SEXUAL ABUSE HEALING EDUCATION⁷⁶

WHAT IS CHILD SEXUAL ABUSE HEALING EDUCATION?⁷⁷

Child survivors of sexual abuse need ongoing psychosocial support throughout their case management. Providing information about sexual abuse to children and family members helps them understand the impact of sexual abuse. Children and families learn how to stay safer in the future and how to cope with emotional and physical reactions provoked by abuse. Knowledge empowers children, and helps survivors and family members heal. When a caseworker provides specific, accurate information about sexual abuse and related topics to child clients and family members, this is called healing education. The caseworker's technical knowledge about child sexual abuse (as outlined in Chapter 1) is key to providing high quality psychosocial interventions to children and families, due to the importance of education and correcting false information about child sexual abuse.

Healing education focuses specifically on improving children's and families' functioning abilities to cope with the experience of sexual abuse. Healing education provides additional information (beyond health, safety, legal and psychosocial referral options) intended for children and families affected by sexual abuse, such as: 1) the facts about sexual abuse, to increase the child's sense of understanding of what they experienced; 2) how to stay safe in the future; and 3) how coping and relaxation skills can help children reduce psychosomatic symptoms related to abuse. In addition, there are special healing education sessions for caregivers only, intended to help caregivers provide the best support to children affected by abuse.

⁷⁶ Much of the text in the sample scripts and the guidelines for the interventions is taken directly from the evidenced-based model, Trauma Focused Cognitive Behavioral Therapy. <http://tfcbt.musc.edu/>

⁷⁷ The technical term for this is psychoeducation. However, the CCS Initiative prefers the term healing education as it translates more easily in multiple language and settings, as evidenced by the CCS pilots in Thailand and Ethiopia.

WHAT ARE THE TOPICS?

Healing education for children and families can be divided into three categories:

- » **Topic 1.** About Sexual Abuse: What Every Child and Caregiver Should Know.
- » **Topic 2.** Staying Safe! Body Safety and Safety Planning.
- » **Topic 3.** Caregiver Session: Caregiver's Role in the Child's Healing Process.

For caseworkers providing healing education, tips and guidelines for providing healing education sessions are provided below. Remember, the way this information is shared and communicated will need to be adapted based on a child's age and cultural context. Healing education aims to correct false beliefs about sexual abuse, which can lead to blaming the child for the abuse and can often cause further harm to the child survivor. It is recommended that methods for providing healing education for children and families be adapted to the local culture to ensure information is relayed in the most culturally appropriate way possible.

HOW TO PROVIDE HEALING EDUCATION

STEP 1

MAKE AN APPOINTMENT WITH THE CHILD (AND CAREGIVER IF APPROPRIATE)

Caseworkers should ask the child and caregiver if they are willing and interested to participate in a special healing education session. The caseworkers should explain that they would like to share information with the child and caregiver that can help them understand and manage what has happened. Caseworkers should note that the session will take place in a private space and will last no longer than one hour.

How much time a caseworker will have to educate and work with a child and caregiver will depend upon their relationship, the family's willingness to engage, and the context of the situation. Caseworkers will need to work with their supervisor to find ways to structure and deliver the education sessions that cover key information.

STEP 2

CONDUCT THE SESSIONS

As mentioned above, caseworkers will need to determine how many special sessions they can schedule with their clients based upon their relationships and the opportunities for follow-up appointments. If there are opportunities for the caseworker to meet regularly with the child client, he/she should aim to schedule at least three sessions to provide healing education and

support. If the caseworker can plan only one session, then he/she will want to cover as much information as possible with the child and caregiver.

THE FIRST HEALING EDUCATION SESSION

During the first healing education session with the child and caregiver, the caseworker should cover information included in Topic 1: About Sexual Abuse: What Every Child and Caregiver Should Know, and if there is time, Topic 2: Body Safety and Safety Planning.⁷⁸

TOPIC 1: ABOUT SEXUAL ABUSE: WHAT EVERY CHILD AND CAREGIVER SHOULD KNOW

Children and caregivers need to have accurate facts about child sexual abuse. Caseworkers should always explain that child sexual abuse is not the child's fault and he/she is not to blame. Indeed, understanding sexual abuse is important for the child's and family's healing and recovery process. This is why we start with facts about sexual abuse when providing healing education to children and families. The key facts and information to cover in the first session include:

- a. Explanation of what child sexual abuse is.
 - b. Why it happens and who perpetuates it.
 - c. How children may feel after sexual abuse (common reactions).
 - d. Children's tendency to remain silent about abuse (especially important for caregivers).
-
- a. **What Is Sexual Abuse: Key Information in Appropriate Language**
 - Child sexual abuse is when an adult or someone older than you touches or rubs your private parts or makes you engage in sexual activity or witness sexual acts. Sometimes the older person asks you to touch his private parts. Sexual abuse is also when someone talks sexually to you, makes you watch sexual videos or look at sexual pictures, or does sexual things in front of you.
 - Sexual abuse is always wrong, and it's always the perpetrator's fault.
 - **Note:** This information section should be adapted to include information specific to the local context.
 - b. **Why Sexual Abuse Happens and Who Perpetrates Abuse: Key Information in Simple Language**
 - Sexual abuse happens to a lot of children. It happens to boys and girls of all different ages. It doesn't matter whether you're rich or poor—sexual abuse happens to lots of different kids all around the world.

⁷⁸ These topics can be separated into two sessions if needed.

- The important thing to remember is that being sexually abused is not your fault; it's not about what you look like or anything that you did.
- The perpetrator can be someone you know, like your relative or a close family friend. Or, the perpetrator could be a complete stranger.
- Most of the time, children are sexually abused by someone they know and trust.

c. How Children May Feel After Abuse, Common Reactions: Key Information in Simple Language

- Children have many different feelings when they are sexually abused and after sexual abuse. The different feelings can be hard to understand. It's ok for children to have lots of different feelings about the abuse.
- Some children feel really mad at the person or afraid of him. Some children feel sad and don't want to talk to anyone. Some children even feel guilty about what happened.
- All these feelings are okay and common.
- Sometimes these feelings can affect how kids behave. Some children feel scared after being abused, and don't want to sleep alone or don't like to be alone.
- Some kids feel mad a lot and they get into lots of fights. Some kids feel real sad and just want to cry all the time.
- It really helps to talk about all of these feelings.

d. Why Children Don't Tell: Key Information, Especially for Caregivers/Parents

- There are lots of reasons why children don't tell an adult when they have been abused.
- Sometimes, the person who did the abuse tells the child that it's 'a secret,' and that they shouldn't tell anybody.
- Sometimes the person makes threats and says things like 'if you tell anyone, I'll hurt you, or I'll hurt your family.'
- The person who hurt your child may even tell your child that no-one will believe them if they tell.
- Sometimes, kids don't tell because they're ashamed or embarrassed or afraid that they'll get in trouble.
- It's important for you to understand what happened is not your child's fault. Your child needs support and acceptance from you.
- You may have many feelings about your child being sexually abused. We can talk about your feelings and how to support you as well.

TOPIC 2: BODY SAFETY AND SAFETY PLANNING

In addition to regular and consistent safety assessments, caseworkers should have a separate session with children and caregivers on body safety and safety planning. Children need to have the communication skills and the confidence to respond to potentially abusive or traumatic experiences. While personal safety skills training does not guarantee the child will be 100% safe, it may help children feel more control and confidence to respond to threats when they occur. Key information to cover in the staying safe session:

- a. Be attentive and knowledgeable.
- b. Be cautious and prepared.
- c. Be assertive!

a. Be Attentive and Knowledgeable

Caseworkers will need to teach children about possible dangers in their environment and help them pay attention to their intuitions. It is helpful if children can recognize danger signs that indicate heightened risk, and to have children rehearse how they might respond to danger. These discussions may also have taken place in the standard case management.

b. Be Cautious and Prepared

As part of overall safety education, caseworkers talk with children about what to do if/when they feel unsafe. Have children practice proper responses to danger or potential violence through role playing, etc. This can help increase the child's self-confidence and efficacy in handling a potential threat. When teaching a child about safety planning, caseworkers should discuss the following:

- Help the child name some adults that make him/her feel safe (If the child is having difficulty, the caseworker can ask about specific people, such as a teacher, a caregiver, a sibling, a friend). Once the safe people are identified, the caseworker can encourage the child to tell them if they feel worried or unsafe (as part of safety planning, these people should be involved/included in a session to formally acknowledge them as "safe people" in the child's life).
- Help the child name places that make them feel safe, especially those places they would go if they didn't feel safe at home.
- Map out a plan with the child and practice how the child would respond if he/she felt unsafe. What would he do? What would he say? It is important to have children practice saying "No!" to an adult who is doing anything to make them feel uncomfortable. Role playing is very useful to help children practice saying "No."



Photo: Gina Bramucci/the IRC

c. Be Assertive

This education should start with a review about what is okay and NOT okay touching. Children should practice what they would do if they experience NOT okay touching. It is helpful to explain to the child the following points:

- Nobody should touch your private parts in a sexual way; even if it is someone you know and love.
- If you feel funny, strange or uncomfortable about the way someone's touching you, you should tell that person, "NO!"
- Give children techniques (run, hide, ask for help, call out, scream) to use in response to inappropriate touching or behaviors. Make sure to help the child identify a trusted adult whom he/she can confide in if anyone threatens them again.
- During this session, it is important for the caseworker to help develop the child's confidence and skill in protecting their bodies. As part of this, it is good to review the safety plan that was created with the child during case management services.

HELPFUL TIP

Be wary of sending the message that if abuse happens again it is the child's fault. Sexual abuse is always the fault of the perpetrator, and children who have been taught how to better protect their bodies may still experience abuse. This is NOT BECAUSE the child was unassertive or ill-prepared enough to protect themselves. It is because the perpetrator has more power over the child and the child is in no way responsible for any abuse.



TOPIC 3 (CAREGIVER SESSION): CAREGIVER'S ROLE IN CHILDREN'S HEALING PROCESS

Caregivers and parents play an essential role in children's healing. In fact, healing is facilitated when children are supported by friends and family in their home and community environment. Caseworkers should organize a caregiver session to allow caregivers a chance to share their understanding and feelings about sexual abuse. Caregivers are under a lot of stress after sexual abuse occurs. They may feel guilty for a variety of reasons, such as: not protecting the child; anger because they feel the child has brought them shame; anger at the perpetrator; confusion about what to do next; and many other tumultuous emotions.

During the caregiver session, caseworkers should allow caregivers to express their feelings and voice their concerns without judgment. However, caseworkers should challenge caregivers if they appear to blame the child for the abuse or if they take judgmental attitudes toward the child. Key topics to cover during the session include:

- a. The role of caregivers in children's healing.
- b. What caregivers should watch for and how they can help.
- c. The care services available for the caregiver.

a. Role of the caregiver in children's healing

- Caregivers play an essential role in children's healing. Many children more easily recover from the impacts of sexual abuse when they have support from their mothers, fathers and families.
- Caregivers need to encourage the whole family to lend support to the child. The family should treat the child with compassion and make the child feel loved.
- Children should continue to go to school, play and "be children" after sexual abuse. Sexual abuse should not prevent the child from continuing to develop and engage in child appropriate activities.

b. What to watch for and how to help

- If the caregiver notices their child is behaving differently (for example, refusing to go to school, to see friends, or other changing behaviors) they should talk to their child and, if appropriate, seek help.
- Caregivers can help children by not blaming them for the abuse, making them feel comfortable and happy at home, and allowing them time and space to come to terms with the experience in their own way.
- Caregivers should protect the child and make sure they will not be harmed by the perpetrator or anyone else.
- Caregivers should encourage their child to go back to school and resume daily activities.
- Caregivers should not discuss the abuse with neighbors or other people. Caregivers should not discuss the child's sexual abuse in front of the child (unless the best interest of the child indicates that the caregivers talk about the abuse with a medical doctor, legal counselor or caseworker).
- Caregivers should always reinforce that sexual abuse is always wrong, and always the perpetrator's fault.

c. Care for the caregiver

Caregivers, especially if they are mothers, may blame themselves for the sexual abuse.

Caseworkers will need to encourage mothers and not blame them for the sexual abuse.

- Caregivers may also experience strong reactions after sexual abuse happens in their family. They may feel sad, angry, depressed, scared or confused. This is okay. It is normal for people affected by sexual abuse to experience these emotions.
- Caregivers may blame themselves for the abuse. But sexual abuse is ALWAYS the fault of the perpetrator. It is not the child's fault and it is not the caregiver's fault.
- Caregivers should talk to friends or other trusted people if they are having a hard time doing their daily work because of their reactions to the sexual abuse.
- Caregivers should have free access to the caseworker to discuss their feelings about their child's sexual abuse and to find better ways to cope with the impact of the abuse.



HELPFUL TIPS FOR CASEWORKERS

During the session: The caseworker must be certain to listen carefully to the thoughts and feelings expressed by the child and caregivers. During the process of educating children and families, the caseworker may hear parents make statements that may be harmful for children to hear. The caseworker will need to address any beliefs that are potentially harmful for children or these judgments could serve as obstacles in the healing process (for example, if the caretaker appears to blame the child for the abuse and misdirects anger toward the child).

During the session: Always adapt communication techniques (and to some extent the information shared) to the child's age and developmental level. Information should be geared to the child's level of understanding. For example, with younger children, basic information should be provided through drawings, play and role playing. For older children, written materials are useful. This gives them the opportunity to understand things on their own and then ask questions to engage in dialogue.

During the session: Try to include supportive caregivers. Supportive caregivers and children should be provided healing education together so long as the child is comfortable and the caregiver is committed to the child. Having children and caregivers together allows the caseworker to address any misconceptions either the child or caregiver has about the sexual abuse and creates an opportunity for the caseworker to state openly to both the child and caregiver/parent that the abuse is not the fault of the child.

If the caregiver becomes angry: If caregivers begin to blame the child during the session, the caseworker should politely ask them to leave. It is not good to continue a session with a child if caregivers are unable to control their feelings and reactions. The caseworker can work with the caregiver separately in a caregiver session. While anger is a normal human emotion and may be important to the caregiver's healing process, the caseworker and caregivers should work together to manage the caregiver's anger, especially in front of the child.

Ending the session: Before the session is finished, caseworkers should review the information they have discussed with the child and caregiver. The caseworker should ask both parties what they believe has been most helpful in the session. It is also important for the caseworker to ask the child and the caregiver if they have any questions about the information provided during the session. Before the child and the caregiver leave, offer them the chance to join another education session the following week, if appropriate.

INTERVENTION 2: RELAXATION TRAINING⁷⁹

Caseworkers can teach children new ways to cope with stress and reduce physiological symptoms such as racing or pounding heart, difficulty sleeping or concentrating, anger, anxiety, etc. Research suggests children tend to express stress in physical ways. For example, children can report physical symptoms (e.g., headaches, stomachaches, nausea, nondescript aches and pains) when they are experiencing emotional stress. This does not mean that their physical symptoms are not real; they are very real. Children can benefit from understanding the link between emotional stress and its impact on the body. By learning techniques to relax the body, children can gain tools to help reduce their physical symptoms.

This section will introduce two relaxation techniques that caseworkers can teach children and caregivers. Please note that these techniques may not work for all children. It is recommended that social service providers determine what local activities can be promoted to help children relax. Samples can be saying a prayer; watching a candle flicker; dancing and singing; and/or any other technique that can help a child relax his/her body and mind. The relaxation techniques described in this section are:

- » Controlled “belly breathing.”
- » Body relaxation.

RELAXATION TECHNIQUE: CONTROLLED BELLY BREATHING

Controlling our breathing is a useful technique to help children and adults manage anxiety and stress. It's usually taught to help children cope with stressful thoughts and situations that are likely to occur as a result of being abused. The goal of controlled breathing is to have children focus on their breathing so that they breathe deeply and slowly. Breathing in this manner tends to relax their physical body. Controlled breathing teaches several lessons. First, children learn that they can control some of their automatic functions. They also learn that they can eliminate or reduce feelings of tension or anxiety. Finally, they learn that by concentrating on their breathing patterns, they can distract themselves from unpleasant thoughts or images. One advantage of a tool like controlled breathing is that caseworkers can demonstrate it to children and can also monitor closely their progress in using the strategy correctly. When teaching controlled breathing to children, the following steps should be taken:

⁷⁹ Much of the text and interventions in this section comes from the Trauma Focused Cognitive Behavioral Therapy model developed for child survivors of sexual abuse. For more information, please go to: <http://tfcbt.musc.edu/modules/breathing/technique/index.php?f=4>.

6 PSYCHOSOCIAL INTERVENTIONS FOR CHILD SURVIVORS

STEP 1

EXPLAIN THE BELLY BREATHING TECHNIQUE.

Caseworkers will need to explain to the child why they should learn a breathing technique. A sample script could be:



SAMPLE SCRIPT

"Today we're going to learn one way to help ourselves calm down and control our nervousness and upset feelings. I'm going to show you a breathing activity that can help you calm your mind and your body. When we get upset, we tend to breathe faster and not as deeply. This does not allow enough air into our lungs, which can make our body feel out of control. Doing this breathing exercise when you are upset will help you get more air into your lungs. Controlling your breathing will help your body and mind relax. It's also something you can do anytime and anywhere. When you get good at it, we will also show your caregiver how to do it, too."

STEP 2

DEMONSTRATE THE BELLY BREATHING TECHNIQUE.

Caseworkers should show the child how to breathe in and out slowly. The directions for controlled breathing are:

- » Get into a comfortable position (either lying down or sitting comfortably in a chair).
- » Concentrate on breathing, inhaling and exhaling through the nose. One hand should be on the stomach and one hand on the chest. When inhaling, the hand on the stomach should move up, and when exhaling it should move down. The hand on the chest should stay still and not move the whole time.

STEP 3

HAVE THE CHILD PRACTICE BELLY BREATHING.

- » Some children might like to lie on the floor with a small toy or object on their belly. With each breath, the object should move up and down.
- » Be sure to praise the child as he/she practices the technique. Once the child has tried a few breaths, instruct the child to breathe more slowly on the exhalations than on the inhalations. It can help to count during breaths, by saying the following:
 - “First take slow deep breaths in through your nose. Count in 1...2...3 and watch your stomach, not your shoulders, rise. Then breathe out 1...2...3...4...5 and watch your stomach fall.”
- » Once the child is able to get into a breathing rhythm, have him/her choose a word to say silently while they exhale. Good examples are “calm” or “relax.” Instruct the child to try to think only about their breathing and this word. As other thoughts come into his/her head, the child should try to picture them floating away.
- » **Give homework!** Ask the child to practice controlled breathing every day, for 10 minutes. Children can practice while they are falling asleep at night or at another time that is right for them. Older children can record these home practices on a form and discuss later with the caseworker. The caseworker should help the child decide when/where the homework will be done, trying to identify likely barriers to practicing on their own. Initially, the practice sessions should be done when the child is calm and can concentrate, not at times of stress and anxiety.

HELPFUL TIP: INCLUDE THE CAREGIVERS/PARENTS

Parents can be taught controlled belly breathing in order to help their children learn and practice these skills at home. In addition, parents often benefit from these skills themselves, given the high levels of stress they may be experiencing. The same controlled breathing technique taught to the child can be taught to the parent. To help reinforce the skill, children can be involved in teaching their parents the technique in session.



6 PSYCHOSOCIAL INTERVENTIONS FOR CHILD SURVIVORS



Photo courtesy of IStockPhoto.com

RELAXATION TOOL: BODY RELAXATION

Children and adults can use this tool as a way to relax their bodies and decrease muscle tension. This is helpful for children and adults who have trouble falling asleep or who have physical symptoms of anxiety. Body relaxation is usually taught by having people alternate between tensing and relaxing their muscles. Focusing on this difference teaches children how to recognize tense feelings and neutralize them. There are many ways to teach children relaxation skills, some of which depend on the child's age. This section will explain some of them, but caseworkers should always feel free to be creative when helping children learn to relax. Games, dance, music and other activities can be used to teach the technique.

STEP 1

EXPLAIN BODY RELAXATION.

Caseworkers will need to explain what body relaxation is and why it is important. A sample script could be:



SAMPLE SCRIPT

"Sometimes we all feel a little scared or nervous. When we have these feelings, our bodies can get tense or tight. This is an uncomfortable feeling; sometimes it even hurts. To help get rid of these tense feelings, we're going to help you learn to relax your body. This can help you feel looser and calmer."

STEP 2

LEAD THE CHILD THROUGH BODY RELAXATION EXERCISE.

Caseworkers should be trained in (and know how to practice) body relaxation to make sure they can demonstrate it effectively. Caseworkers can guide children in body relaxation techniques by following these directions:

1. Have the child sit in a comfortable position. Lying down is okay, too. The child should get as comfortable as possible. Have the child close their eyes if they would like.
2. Tell the child, "Take a deep breath in and out through your nose. Do this again. What you'll be doing is tightening and relaxing specific muscles in your body. Concentrate on how your muscles feel, specifically the difference between tight and relaxed. After tightening, a muscle will feel more relaxed."
3. Here is sample script to read to the child:

"First concentrate on the large muscles of your legs. Tighten all the muscles of your legs. Feel how tight and tense the muscles in your legs are right now. Hold it for a few moments more...and now relax. Let all the tension go. Feel the muscles in your legs going limp, loose and relaxed. Notice how relaxed the muscles feel now. Do you feel the difference between tension and relaxation? Enjoy the pleasant feeling of relaxation in your legs."



Now focus on the muscles in your arms. Tighten your shoulders, upper arms, lower arms, and hands. Squeeze your hands into tight fists. Make the muscles in your arms and hands as tense as you can. Squeeze harder...and harder...hold the tension in your arms, shoulders, and hands. Feel the tension in these muscles. Hold it for a few moments more...and now release. Let the muscles of your shoulders, arms and hands go limp. Feel the relaxation as your shoulders lower into a comfortable position and your hands relax at your sides. Allow the muscles in your arms to relax completely.

Focus again on your breathing—slow, even, regular breaths. Breathe in and relax. Breathe out the tension. Breathe in and relax. Breathe out the tension. Continue to breathe slowly, in and out.

Now tighten the muscles of your back. Pull your shoulders back and tense the muscles along your spine. Arch your back slightly as you tighten these muscles. Hold...and relax. Let go of all the tension. Feel your back comfortably relaxing into a good and healthy posture.

Turn your attention now to the muscles of your chest and stomach. Tighten and tense these muscles. Tighten them further...hold this tension...and release. Relax the muscles of your chest and stomach.

6 PSYCHOSOCIAL INTERVENTIONS FOR CHILD SURVIVORS

Finally, tighten the muscles of your face. Scrunch your eyes shut, wrinkle your nose and tighten the muscles of your cheeks and chin. Hold this tension in your face...and relax. Release all the tension. Feel how relaxed your face is!

Try to think about all the muscles in your body...notice how relaxed your muscles feel. Allow any last bits of tension to drain away. Enjoy the relaxation you are feeling. Notice how calm you breathe, how relaxed your muscles are. Enjoy this relaxation for a few moments."

STEP 3

When the child is ready to return to the usual level of alertness and awareness, have them slowly reawaken their bodies. They can wiggle their toes and fingers, swing their arms gently or stretch out their arms and legs.

STEP 4

Encourage children to practice this at home before they fall asleep.

EXPLAINING BODY RELAXATION TO YOUNGER CHILDREN

Younger children will not be able to follow detailed instructions, so caseworkers should be creative when teaching them body relaxation techniques. As an example, caseworkers might teach the relaxation by comparing a body to a noodle or uncooked bean (or another food that is more appropriate in the local setting). Here is an example using an uncooked bean:



» "Have you ever seen beans before they are cooked? What do they look like? They are very stiff. How about beans after they're cooked, what are they like? They are soft and mushy. Let's pretend we are cooked and uncooked beans! First, we'll pretend to be uncooked beans and be very tense and strong and stand up very straight. And then we'll be cooked beans, loose and relaxed and soft. Let's try again (repeat here, having the child follow you): Let's be uncooked beans... okay, now cooked beans... then uncooked beans... then, pause a few seconds and say cooked beans..." (can repeat several times).

INCLUDE THE PARENTS

Parents can be taught body relaxation in order to help their children practice these skills at home. In addition, parents benefit from these skills themselves, given the high levels of stress they may be experiencing. The same body relaxation techniques taught to children can be taught to their parent. To reinforce the skill, children can help teach their parents in session.

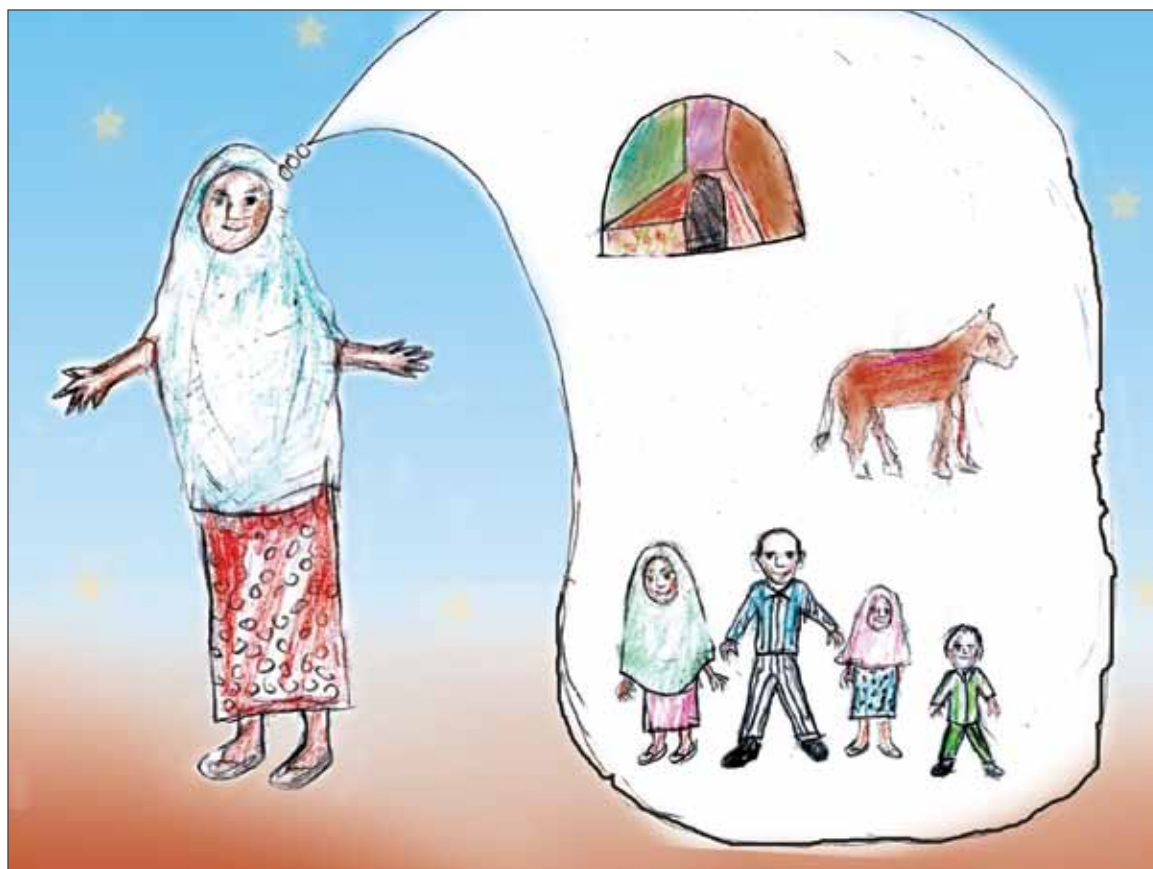


Illustration by Abdifatah Abdukadir Osman

INTERVENTION 3: HELP CHILD WITH COPING SKILLS

The aftereffects of sexual abuse can be hard for child survivors. They may feel ashamed and sad. They may refuse to attend school and spend large amounts of time by themselves. They may have a hard time finding the right people and resources to help them cope with the impact of sexual abuse. Children need to remember that they are strong, and that it's possible for them to heal, recover and live happy and healthy lives. While we can provide children with techniques they can use to relax their bodies and minds, caseworkers may need to help children develop a coping plan which includes social support and activities that build on their interests and strengths. Through such a coping plan, caseworkers can encourage children to participate in positive activities that they enjoy. The more active children's lives are, the better their moods and more likely they are to return to normal functioning (going to school, playing with friends, talking with others, etc.). During the assessment, if children identify negative feelings, the caseworker can initiate a series of questions to help them develop a coping action plan.

3-STEP COPING PLAN PROCESS

- » **Step 1:** Ask children, “When you feel [sad or lonely or scared—whatever the child has expressed their feeling to be], who can you talk to?” Then have children list the people they feel comfortable talking with.
- » **Step 2:** Identify the activities children enjoy. Building on the information the caseworker gathered during the assessment, identify the child’s interests, activities and strengths. The caseworker can then help children identify positive feelings (happy, relaxed, etc.) associated with the interests and activities they described.
- » **Step 3:** Building off the child’s answers, the caseworker can develop a plan with the child to engage the people, activities, interests and other strengths they have identified, to help them when they need support. The caseworker can ask caregivers to support the child in carrying out the plan. The caseworker can follow-up with the child and caregiver at their next meeting to find out if they have tried the plan and whether or not it is helping the child to feel better.

Some useful activities caseworkers can do with children to help them identify their own strengths and interests may include:

- » Talk/draw/play games with children to help them identify the people they feel safe with and supported by. Be sure children know how to locate these people.
- » Talk/draw/play games with children to learn about their faith and their spiritual beliefs. Help children reconnect to faith if they are feeling isolated.
- » Talk/draw/play games with children about what they can do when they feel sad. Find out what kind of activities make them happy and who are their friends and “safe people.”
- » Encourage children and help them recognize their own strengths. Praise them. Children need to see themselves as capable human beings who deserve love, happiness and protection.

INTERVENTION 4: PROBLEM SOLVING

During the psychosocial assessment, children may report difficulties or problems they face in their day-to-day lives. Children may find themselves struggling to feel accepted by a parent or friends, or they may have problems going back to school. There are many different kinds of problems that children will face, and it is likely that not all of these problems are directly related to the sexual abuse the child experienced. Other contributing factors can be: money stressors at home; alcoholism at home; the child has not been going to school for a long time; the child is engaged in harmful work; or perhaps the child is living on the street. It is nevertheless important for the caseworker to take the time to listen to the child and give the child the opportunity to talk about their problems. Caseworkers assess children’s main problems throughout the

psychosocial needs assessment, and with this information can help children take steps to solve the most important problems they face. Caseworkers can follow these simple steps to help children identify their own power in being part of solving problems they face, while supporting them fully in the problem solving process.

STEP 1

IDENTIFY THE PROBLEMS WHICH CONCERN THE CHILD THE MOST.

Caseworkers can ask question such as, “What worries you the most right now?” or “What problems do you have right now?” (This information should be in the first section of the assessment.) Some children may have a hard time answering such questions. Caseworkers can also refer to information gathered during the initial assessment. For example, a caseworker might say, “When we first talked, you mentioned that you are not going to school right now, but this is an activity that you enjoy. Can you tell me more about why you are not in school?”

Depending on the problems identified, the caseworker will then need to assess which problems are directly related to the sexual abuse and work with the child on a plan to address these problems. Problems of broader concerns related to the well-being of the child must also be taken into consideration. The caseworker will either provide advice to the child on how to address these issues, or refer the child for further services and support which are beyond the capacity of the caseworker.

STEP 2

PRIORITIZE THE PROBLEMS.

If multiple problems are identified during the assessment, hopefully some of them can be addressed through the stress reduction, education and coping skills interventions; otherwise, further referrals need to take place to ensure appropriate further support for the child. The caseworker should work with the child to prioritize problems that concern the child the most, and can be addressed at some level of intervention. Based on these problems, the caseworker needs to decide whether a referral for further support is needed or whether the problem can be addressed through the psychosocial interventions. For example, if a child is worried he/she is being blamed by family for the abuse, the caseworker can conduct a healing education intervention with the caregivers and work with the child to identify other actions to solve this problem. In other situations, a referral may be needed. For example, if the child is living without an adult caregiver, the caseworker would need to inform the child protection agency. For direct interventions by the caseworker, generally, caseworkers should keep the problems limited to 3 or less, and be sure that concrete actions can be taken toward solving the problems.

The caseworker can use a ranking exercise to help the child prioritize the problems she/he is experiencing. This starts with a free listing of all problems faced by the child and identified during the assessment. The caseworker and/or child can write/draw each of these on a piece of paper or use a symbol for each problem (e.g., a book to represent school), and place these on a table or the floor. The caseworker then asks the child to identify out of the total list which 3-5 problems she/he considers to be the biggest problems from the child's perspective. If the problems are written/drawn on a piece of paper, the child can mark the key problems. If the problems have been symbolized, the child can lift the key problems and place them in another site.

It might be that the child prioritizes problems which the caseworker does not consider to be the most important problems, but it gives an important insight to the experience of the child, and should not be denied. The next step here could be for the caseworker to do a ranking of 3-5 problems from the caseworker's perspective. There might be overlaps, which should be the areas that need to be addressed. In situations where the caseworker might have prioritized different problems, there needs to be a discussion around these differences and why these were prioritized. If the differences are minimal, all problems can be included in the problem solving plan. If the differences include many problems, a further ranking can take place based on the combined child's and caseworker's initial ranking.

STEP 3

DEVELOP A PROBLEM SOLVING PLAN WITH THE CHILD.

Problem solving requires some simple steps. The first step is to identify the problem. The second step is to identify a goal (in other words, what the child's life would be like with the problem solved). The third step is to brainstorm all possible solutions to the problem and those that can be accomplished by the child, caregiver, caseworkers or others who can offer help. Problem-solving steps must be concrete and specific. Here is an example:

CASE DESCRIPTION

Alisha is worried that her father is going to be angry when he comes home and finds out she was raped. Alisha is worried that her father will throw her out of the house. Until now, Alisha has had a good relationship with her father and her mother is supportive of her. Alisha furthermore indicated that she has problems at school, as her classmates ignore her and she is excluded from the recreational activities happening in and around school—this has been happening for a long period of time.

MAIN PROBLEMS AND GOALS

1. Alisha's father will punish her for being raped. Alisha's goals: to be accepted and not blamed by her father; to live happily at home.
2. Alisha is not included in recreational activities by her classmates. Alisha's goals: to be accepted by her classmates and to take part in recreational activities.

POSSIBLE SOLUTIONS (brainstormed by the caseworker and Alisha together)

- » Alisha shares her fears with her mother.
- » Caseworker and Alisha's mother sitting with the father to explain the situation to him.
- » Having someone whom the father respects and trusts involved to help tell the father what happened.
- » Have a backup plan for Alisha in case her father does force her to leave home.
- » Help Alisha cope with the constant worry about her father.

PROBLEM SOLVING PLAN

Based on the possible solutions brainstorm, Alisha and the caseworker decided on the following actions to solve the problem. There are different ways to help children develop a plan to address their stated problems. See Alisha's problem solving plan below.

ALISHA'S PROBLEM SOLVING PLAN

PROBLEM	GOAL	SOLUTIONS	WHEN	WHO
ALISHA'S FATHER WILL PUNISH HER FOR BEING RAPED	Alisha's father to accept her and not blame her.	Discuss Alisha's fear.	Next week.	Caseworker, Alisha's mother and Alisha.
		Meet father with support person.	When he comes home.	Caseworker and Alisha's mother.
		Provide education to father to help him accept and understand what happened.	When he comes home and 3 times after the initial meeting.	Caseworker and Alisha's mother as she wishes.

6 PSYCHOSOCIAL INTERVENTIONS FOR CHILD SURVIVORS

PROBLEM	GOAL	SOLUTIONS	WHEN	WHO
		Make back-up plan...	Next meeting.	Caseworker and Alisha.
ALISHA NOT INCLUDED IN RECREATION-AL ACTIVITIES	Alisha's classmates to accept her and invite her to participate in activities.	Referral to teacher of school.	Today.	Caseworker.
LIST ADDITIONAL PROBLEMS HERE				

Problem solving plans can come in many different formats. They can be in a diagram as shown above; they can be in a simple list format. Caseworkers and children can use drawings or symbols rather than words to describe the problem, goals and steps toward solving the problem.

CONCLUSION

This chapter described how to conduct a more comprehensive child and family psychosocial needs assessment and offered targeted psychosocial interventions for children. Offering direct psychosocial interventions to children and families works best in contexts that are stable and where caseworkers have regular access to clients over time. This is because the psychosocial needs assessment and delivery of psychosocial care requires the caseworker to meet regularly with the child (and family members as appropriate) over a period of time.

Caseworkers should discuss with their supervisors what happens after each meeting with the child survivor. This allows for reflection on what worked and didn't work, and for case supervision if difficulty arises when conducting the assessment and delivering psychosocial interventions.

Child and Family Psychosocial Assessment

Caseworker code	Date	Time
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Part II: Main Problems/Worries

For this section, case workers should use questions and/or drawing activities with children get a sense of what their main problems and concerns are following the experience of abuse. In this box, case workers should write down the current status of the child based on his or her own words.

PART III: Family, Social & Spiritual Context

Family & Living Situation: Guidance for assessment: where does the child live (sleeps, eats, hangs around); who lives in the house and visits frequently; number of siblings, does the child appear happy in the home? Is the child able to play freely and where? Does the child appear afraid and/or not close to with parents/guardians, siblings; Is the child treated differently to other children in the family?

Social Support (friendships, school, participation in social and community life)	Spiritual/religious:
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Other Notes: (e.g. safety risks identified, etc)

PART IV: Child Functioning Assessment

DIRECTIONS: The caseworker should ask the child survivor these questions in a private, confidential room. Say: I'm going to read some sentences. Please tell me how TRUE these sentences are about you. Think about how true these things are since _____
[describe abusive event...e.g., you were raped]

<i>There can only be the X mark in one column.</i>	YES	NO	COMMENTS
1. I don't see my friends as much as I used to.			
2. I have stopped my daily activity (e.g. school).			
3. I am having fights with people more than I used to.			
4. I am having a hard time going to sleep or staying asleep.			
5. I am having body aches, stomachache, headache or other aches.			
6. I worry that something bad is going to happen.			
7. I am feeling sad and hopeless.			

PART V: Caregiver Assessment (if possible)

What is your understanding about the abuse and what happened?	
What are your feelings about the abuse and what happened?	
What changes have you noticed with your child since the abuse?	
What do you think will help your child right now?	
What are your main worries and needs right now?	

PART VI: Child & Family Strengths

Survivor Code:

Incident ID:

Child Strengths/Protective Factors

(things the child enjoys going, positive relationships to caregivers, people they trust and who support them, able to solve problems, feel hopeful, laugh, etc)

Caregiver & Family Strengths/Protective Factors

(strong and positive relationship with their child, other family members; able to cope with stress; social and community support; job/income)

PART VII: Psychosocial Evaluation & Action Planning

(for the caseworker to complete only)

Assessment Questions	Yes	No	N/A	Action Plan for Intervention (include, what is the action, who is responsible and timeframe)
1. Did the child report having problems functioning (See functioning items 1-3). If yes: interventions required: 1. Problem solving 2. Healing education 3. Relaxation training				
2. Did the child report feeling anxious or worried (See Functioning items 4-6). If yes: interventions required: 1. Relaxation training 2. Healing education Problem solving (if needed)				
3. Did the child report having negative feelings (See Functioning items 7-8). If yes: interventions required: 1. 3-Step Coping 2. Healing education 3. Relaxation training				

Survivor Code:

Incident ID:

List the strengths (child and family) that can support the child’s healing.
(school, activities, sense of humor, etc).

Other areas of need identified during the assessment that require intervention (direct and/or referral)
(if not addressed above)

Identified Need:	Action Plan (include what action, who will do what, and timeframe).
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Next Follow Up Appointment scheduled for (date/time)



Chapter Seven

BEST PRACTICES FOR CASE COORDINATION BETWEEN SERVICE PROVIDERS

This chapter applies to service providers responding to cases of sexual abuse.

CONTENTS OF THIS CHAPTER INCLUDE

- » Concise overview of best practices in case coordination

TOOLS

- » Indicators for direct case coordination best practice

CHAPTER OVERVIEW

This chapter outlines best practices in direct case coordination to prevent harm to the health and well-being of child survivors as their care is coordinated. Caring for child survivors requires skilled service providers to provide appropriate care and treatment, and good case coordination amongst service providers. This chapter outlines best practice in case coordination and includes a set of indicators that provide a benchmark for case coordination actions that promotes children's best interest, protection and confidentiality.

BEST PRACTICE IN COORDINATING CHILD CASE RESPONSE

1. Developing Community-Based Interagency Protocols for Responding to Child Sexual Abuse

Interagency protocols⁸⁰ outlining referral and response procedures, as well as the roles and responsibilities of agencies, should be developed and signed by all relevant actors at the local level. Guidelines for how to establish interagency protocols have been developed by the *IASC Sub-Working Group on Gender & Humanitarian Action*,⁸¹ and the development and utilization of agreed upon protocols for responding to GBV and child protection are standard in most humanitarian aid settings. It is recommended that interagency protocols for responding to GBV and/or child protection issues outline specific procedures for working with child survivors of sexual violence. This includes actors agreeing to:

- The roles and responsibilities of actors in child sexual abuse response (e.g., services) and prevention.
- A set of guiding principles for working with child survivors of sexual abuse.
- Specific reporting and referral mechanisms for child survivors (this includes mapping of referral systems among service providers with specialized skills in responding to child sexual abuse).
- Outline of relevant mandatory reporting laws and policies in the local context and how they will be specifically addressed at the local level.
- Guidelines for informed consent and confidentiality procedures in child cases.

In settings where interagency protocols exist for both GBV and child protection, efforts should be made to link the different protocols to ensure consistency in child sexual abuse case response and referral.

2. Information Sharing Protocols

Information sharing about a child client's case is necessary in case coordination and should be decided by the child client and his/her caregiver as appropriate. Information sharing protocols are typically included in Interagency Protocols (described above) and

⁸⁰ Also often referred to as Standard Operating Procedures (SOPs)

⁸¹ These guidelines can be found at: <http://oneresponse.info/GlobalClusters/Protection/GBV/Pages/Tools%20and%20Resources.aspx>

can be further detailed in direct service provider agreements between 2 or more agencies who commonly work together. At a minimum, information sharing protocols should generally cover the following:

- How referrals should be made (e.g., use of a form, verbal, etc).
- What sort of referrals can and cannot be accepted (e.g., A GBV service providing agency may not accept a child case that does not involve GBV).
- The type of information that can be shared between agencies (with the client's consent and/or caregiver's consent as appropriate).
- How that information may be used.
- The timeframe for response.

These details should be documented and agreed upon by agencies providing services to children. Sharing client information is very sensitive and clients need to know which information will be shared and how that information will be used. Common tools used in case referral and coordination include a referral form and a consent form (to keep with client records for the release of information to or from another service).

3. Direct Service Provider Agreements between Child Protection and GBV Service Providers

While broad interagency protocols guiding referral and response procedures are essential, in many settings it is helpful to have even more detailed agreements between child protection and GBV programs operating in one setting. Specific agreements between child protection and GBV agencies help to facilitate coordination and productive collaboration because such agreements clarify direct case management responsibilities among these service providers in a particular setting. Without coordination agreements between GBV and child protection agencies, staff may inadvertently duplicate services, breach confidentiality, practice informed consent differently, provide children and families with conflicting information (about mandatory reporting, services in the community, etc.) and potentially bring harm to the child survivor and frustrate caregivers. Therefore, it is recommended that service-level coordination agreements are established across GBV and child protection case management organizations, in order to maximize both agencies' positive contributions to restoring safety and well-being.

Direct service provider agreements between GBV and child protection agencies should outline:

- Minimum standards for staff competencies and training prior to working with child survivors.
- Guiding principles for working with child survivors.
- Their respective roles in child sexual abuse case management. This includes outlining circumstances that dictate: when mandatory reports should be made and how; when joint assessments/interviews should be initiated; and when and with whom written case reports/assessments should be shared (always with the consent of the child survivor and/or caregiver).
- If possible, one agency (sector) should be designated as the **lead case management agency** responding to child sexual abuse. An identified lead case management agency for sexual abuse clarifies specific responsibility for key actions made in case response. For example:
 - to whom the child/family is first referred for comprehensive case management services;
 - which agency will be responsible for conducting the initial intake interview and needs assessments, which will guide future case-related actions;
 - which agency will be responsible for reporting the abuse to the relevant authorities (if needed); and
 - which agency will be empowered to “manage and supervise” the case according to the needs of the child survivor and his/her support system.

These agreements are intended to streamline services and coordination for children and families, and to avoid the pitfalls of uncoordinated care. In humanitarian settings where both child protection and GBV service providers are operating, it is the responsibility of the lead coordinating agencies (GBV, child protection and/or health) to take the initiative in developing these more detailed agreements.

COORDINATION ISSUE AT-A-GLANCE: MULTIPLE INTERVIEWS OF CHILD SURVIVORS

The need for a coordinated response to child survivors of sexual abuse cannot be emphasized enough when it comes to the issue of multiple interviews of child survivors. One of the more traumatic experiences that a child faces when interacting with community systems of response is being asked to repeat his/her sexual abuse unnecessarily to different people, or to hear about it from people who should not know about it. This is an unacceptable burden to place on a child, and child protection, GBV, protection/legal, and health programs operating on the ground should develop agreements on how, when, and by whom an interview of a child survivor of sexual abuse should take place. Additionally, these actors should establish when and how this information can and should be ethically shared in a confidential and respectful way.

ESSENTIAL COMPONENTS OF GOOD CASE COORDINATION: A CHECKLIST FOR CASEWORKERS

Case management agencies responsible for coordinating care for child survivors should be aware of these essential components of case coordination to guide their own practice. These components serve as a **checklist** for caseworkers to measure how effectively they are implementing good case coordination:

- » Caseworkers understand and know of other services in the community to respond to the specific needs of children and child survivors.
- » Each child client receives coordinated services based on their individual action plan.
- » Referral agencies are involved in a child's case when this serves the child's and family's best interest.
- » Children and families are in control of which services are involved.
- » Information is shared between service providers, with the permission of the clients.

In addition, the following best practice coordination indicators service provider's can use are outlined on the next page.

BEST PRACTICE COORDINATION INDICATORS

INDICATOR	YES	NO
Standard Operating Procedures (SOPs) , which include referral systems are in place and functioning for child survivors.		
Service providers are able to make safe and effective referrals for children (e.g., understand services in community, who to contact, how to obtain consent, etc.).		
Health, psychosocial and other service providers have the same understanding of mandatory reporting procedures and how to interact with legal/justice systems.		
Service providers adhere to the guiding principles for working with child survivors.		
Information sharing protocols exist and are utilized properly among service providers. Specific safeguards are included to ensure children are not interviewed multiple times about their history of sexual abuse.		
Direct service provider agreements exist between child protection and GBV agencies.		
A lead case management agency is designated (for coordinating care related to the sexual abuse) in the setting to ensure duplicate services are not offered.		
Agencies/staff involved in a child's case attend case coordination meetings called by the lead case management agency as requested/needed.		
Service providers communicate care and belief to children. This means, each service provider tells the child they are brave to come forward; they did the right thing to tell; the abuse is not the child's fault; and the service provider believes the child.		

CONCLUSION

This chapter addresses key aspects to coordination in child sexual abuse cases. Service providers should prioritize establishing clear procedures and protocols for coordinating child cases to ensure that children are no further traumatized by the system of care delivery itself. At the center of quality coordination is ensuring the client's rights are respected and needs are met.



FINAL NOTE TO THE READER

There has been a shortage of technical guidance for health and psychosocial workers on how to care for children who have experienced sexual abuse. The purpose of this document is to begin to fill this gap in guidance. Our hope is that these guidelines will be promoted and used across agencies and service providers in humanitarian settings.

The technical guidance included in this document is not exhaustive by any means. However, we aimed to distill the most essential knowledge, attitudes and skill competencies required by service providers to ensure children and families are offered compassionate care. In addition, the supervision tools and case management forms and checklists can support staff in directing high quality client care. It is expected that agencies will use the case management practices and case forms to be inline with safe and ethical information sharing principles as outlined by the Gender-Based Violence and Child Protection information management systems.⁸²

In conclusion, we would like to share some recommendations made from children across the world for practitioners responding to child sexual abuse. These recommendations come from a 2005 Save the Children Norway report⁸³ and are being shared as a demonstration—and commitment—to create space for children's voices when formulating recommendations aimed at improving their care. Much of their compelling guidance has been weaved directly—and indirectly—throughout the CCS guidelines and has influenced the thinking behind the CCS initiative as a whole. Some key recommendations made by children are:

- | | |
|--|--|
| » Sexual abuse is bad and should not happen. | » I need to feel safe and protected and decide how my case is to be handled. |
| » Tell them to stop—it is hard to disclose. | » Love me, support me—we know what we need. |
| » Listen to me and believe what I tell you. | » Let my abuser face up to what he or she has done. |
| » Talk to me and be there if I need you. | » Don't put a label on me and let me go on with my life. |

It is the responsibility of health and psychosocial service providers to provide compassionate care to children who have survived sexual abuse. We wish you courage and commitment as you continue to help children recover and heal from the impacts of sexual abuse.

⁸² www.gbvims.org and www.childprotectionims.org.

⁸³ Save the Children Alliance (2005). Ten essential learning points: Listen and speak out against sexual abuse of girls and boys. Norway: Save the Children Norway.

Caring for Child Survivors

Minimum Standards for Case Management

CCS PROGRAM MODEL - MINIMUM STANDARDS FOR CASE MANAGEMENT SERVICE PROVIDERS

MUST BE IN PLACE	Yes (1pt)	No (0 pts)	Comments
1. Case Management staff trained on CCS are present in service provider agencies (this means staff delivering services have been trained and pass the core Knowledge/Skills/Attitudes competency checklists)			
2. Supervision systems exists for case workers providing care to child survivors			
3. Safe, locked filing space to keep child records confidential exist			
4. Referral system for children is documented and functioning			
5. A private room counseling room is available for meetings with children and caregivers			
6. Informed consent and confidentiality forms and procedures are adapted for child survivors			

PASSING SCORE MUST BE = 6 points

SHOULD BE IN PLACE	Yes	No	Comments
1. Case management forms are adapted and used for child survivors			
2. Child friendly materials (toys, art materials, dolls) are available in counseling rooms for case management staff to use with child survivors			
3. Sexual abuse educational materials are adapted and available for child survivors			
4. Child supplies (clothes, etc) are available at the case management service location			
5. Defined, psychosocial interventions offered as part of case management.			

Intake and Initial Assessment Form

Instructions	1- This form is to be filled out by a case manager, or social worker providing services to the survivor of GBV. Filling out this form is <u>not</u> the equivalent of providing a service.
	2- Note that questions followed by an asterisk* must remain on the intake form and must be answered. These questions are a part of a minimum essential dataset on GBV. Some questions are followed by both an asterisk* and a circle ^o ; these are customizable, and the italicized text of these fields is intended to be adapted to each context and can be modified. Questions that are unmarked may be modified by your agency or removed if they are not necessary for your program and/or case management.
	3- Unless otherwise specified, always mark <u>only</u> one response field for each question.
	4- Please feel free to add as many questions to this form as needed in your context and/or attach additional pages with continued narrative, if needed.

Before beginning the interview, please be sure to remind your client that all information given will be kept confidential, and that they may choose to decline to answer any of the following questions.

1-Administrative Information		
Incident ID*:	Survivor code:	Caseworker code:
Date of interview (day/month/year) *:	Date of incident (day/month/year) *:	
<input type="checkbox"/> Reported by the survivor or reported by survivor's escort and survivor is present at reporting* <i>(These incidents will be entered into the Incident Recorder)</i>		
<input type="checkbox"/> Reported by someone other than the survivor and survivor is not present at reporting <i>(These incidents will <u>not</u> be entered into the Incident Recorder)</i>		
2-Survivor Information		
Date of birth (approximate if necessary) *:	Sex*: <input type="checkbox"/> Female <input type="checkbox"/> Male	Clan or ethnicity:
Country of origin* ^o : <input type="checkbox"/> Country names here <input type="checkbox"/> Etc.	<input type="checkbox"/> Etc. <input type="checkbox"/> Etc.	<input type="checkbox"/> Other (specify) :
Nationality (If different than country of origin):		Religion:
Current civil / marital status*:	<input type="checkbox"/> Single <input type="checkbox"/> Married / Cohabiting	<input type="checkbox"/> Divorced / Separated <input type="checkbox"/> Widowed
Number and age of children and other dependants:		
Occupation:		
Displacement status at time of report*:		
<input type="checkbox"/> Resident <input type="checkbox"/> Returnee	<input type="checkbox"/> IDP <input type="checkbox"/> Foreign National	<input type="checkbox"/> Refugee <input type="checkbox"/> Asylum Seeker <input type="checkbox"/> Stateless Person <input type="checkbox"/> Other_____
Is the client a Person with Disabilities? * <input type="checkbox"/> No <input type="checkbox"/> Mental disability <input type="checkbox"/> Physical disability <input type="checkbox"/> Both		
Is the client an Unaccompanied Minor, Separated Child, or Other Vulnerable Child?*		
<input type="checkbox"/> No <input type="checkbox"/> Unaccompanied Minor <input type="checkbox"/> Separated Child <input type="checkbox"/> Other Vulnerable Child		
Sub-Section for Child Survivors (less than 18 years old)		
If the survivor is a child (less than 18yrs) does he/she live alone? <input type="checkbox"/> Yes <input type="checkbox"/> No (if "No", answer the next three questions)		
If the survivor lives with someone, what is the relation between her/him and the caretaker?		
<input type="checkbox"/> Parent / Guardian <input type="checkbox"/> Relative <input type="checkbox"/> Spouse / Cohabiting <input type="checkbox"/> Other:_____		
What is the caretaker's current marital status?		
<input type="checkbox"/> Single <input type="checkbox"/> Married / Cohabiting <input type="checkbox"/> Divorced / Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Unknown / Not Applicable		
What is the caretaker's primary occupation:		

3-Details of the Incident

Account of the incident/Description of the incident (summarize the details of the incident in client's words)

Stage of displacement at time of incident*:

- ☐ Not Displaced / Home Community ☐ During Flight ☐ During Return / Transit ☐ Other: _____
☐ Pre-displacement ☐ During Refuge ☐ Post-displacement

Time of day that incident took place*:

- ☐ Morning (sunrise to noon)
☐ Afternoon (noon to sunset)
☐ Evening/night (sunset to sunrise)
☐ Unknown/Not Applicable

Incident location / Where the incident took place*^O:

(Customize location options by adding new, or removing tick boxes according to your location)

- ☐ Bush / Forest
☐ Garden / Cultivated Field
☐ School
☐ Road
☐ Client's Home
☐ Perpetrator's Home
☐ Other (give details) _____

Area where incident occurred*^O:

- ☐ Area names here
☐ Etc.
☐ Etc.
☐ Etc.
☐ Other (specify) : _____

Sub-Area where incident occurred*^O:

- ☐ Sub-area names here
☐ Etc.
☐ Etc.
☐ Etc.
☐ Other (specify) : _____

Camp/Town/Site:

- ☐ Camp/Town/Site names here
☐ Etc.
☐ Etc.
☐ Etc.
☐ Other (specify) : _____

3-Details of the Incident *Cont.***Type of Incident Violence*:**

(Please refer to the GBVIMS GBV Classification Tool and select only ONE)

☐ Rape

(includes gang rape, marital rape)

☐ Sexual Assault

(includes attempted rape and all sexual violence/abuse without penetration, and female genital mutilation/cutting)

☐ Physical Assault

(includes hitting, slapping, kicking, shoving, etc. that are not sexual in nature)

☐ Forced Marriage

(includes early marriage)

☐ Denial of Resources, Opportunities or Services

☐ Psychological / Emotional Abuse

☐ Non-GBV (specify) *Note: these incidents will not be entered into the incident recorder*

1. Did the reported incident involve penetration?

If yes → classify the incident as "Rape".

If no → proceed to the next incident type on the list.

2. Did the reported incident involve unwanted sexual contact?

If yes → classify the incident as "Sexual Assault".

If no → proceed to the next incident type on the list.

3. Did the reported incident involve physical assault?

If yes → classify the incident as "Physical Assault".

If no → proceed to the next incident type on the list.

4. Was the incident an act of forced marriage?

If yes → classify the incident as "Forced Marriage".

If no → proceed to the next incident type on the list.

5. Did the reported incident involve the denial of resources, opportunities or services?

If yes → classify the incident as "Denial of Resources, Opportunities or Services".

If no → proceed to the next incident type on the list.

6. Did the reported incident involve psychological/emotional abuse?

If yes → classify the incident as "Psychological / Emotional Abuse".

If no → proceed to the next incident type on the list.

7. Is the reported incident a case of GBV?

If yes → Start over at number 1 and try again to reclassify the incident (If you have tried to classify the incident multiple times, ask your supervisor to help you classify this incident).

If no → classify the incident as "Non-GBV"

Was this incident a Harmful Traditional Practice*^o?

☐ No

☐ Type of practice

☐ Type of practice

☐ Type of practice

☐ Type of practice

☐ Type of practice

Were money, goods, benefits, and / or services exchanged in relation to this incident*?

☐ No

☐ Yes

Type of abduction at time of the incident*:

☐ None

☐ Forced Conscription

☐ Trafficked

☐ Other Abduction / Kidnapping

Has the client reported this incident anywhere else*?

(If yes, select the type of service provider and write the name of the provider where the client reported); (**Select all that apply**).

☐ No

☐ Health/Medical Services _____

☐ Psychosocial/Counseling Services _____

☐ Police/Other Security Actor _____

☐ Legal Assistance Services _____

☐ Livelihoods Program _____

☐ Safe House/Shelter _____

☐ Other (specify) _____

Has the client had any previous incidents of GBV perpetrated against them*?

☐ No

☐ Yes

If yes, include a brief description:

4-Alleged Perpetrator Information

Number of alleged perpetrator(s)*: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> More than 3 <input type="checkbox"/> Unknown																										
Sex of alleged perpetrator(s)*: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Both female and male perpetrators																										
Nationality of alleged perpetrator:	Clan or ethnicity of alleged perpetrator:																									
Age group of alleged perpetrator* (if known or can be estimated): <input type="checkbox"/> 0 – 11 <input type="checkbox"/> 12 – 17 <input type="checkbox"/> 18 – 25 <input type="checkbox"/> 26 – 40 <input type="checkbox"/> 41-60 <input type="checkbox"/> 61+ <input type="checkbox"/> Unknown																										
Alleged perpetrator relationship with survivor*: (Select the first ONE that applies) <input type="checkbox"/> Intimate partner / Former partner <input type="checkbox"/> Primary caregiver <input type="checkbox"/> Family other than spouse or caregiver <input type="checkbox"/> Supervisor / Employer <input type="checkbox"/> Schoolmate <input type="checkbox"/> Teacher / School official <input type="checkbox"/> Service Provider <input type="checkbox"/> Cotenant / Housemate <input type="checkbox"/> Family Friend / Neighbor <input type="checkbox"/> Other refugee / IDP / Returnee <input type="checkbox"/> Other resident community member <input type="checkbox"/> Other <input type="checkbox"/> No relation <input type="checkbox"/> Unknown																										
Main occupation of alleged perpetrator (if known) *^O: (Customize occupation options by adding new, or removing tick boxes according to your location) <table border="0"> <tr> <td><input type="checkbox"/> Farmer</td> <td><input type="checkbox"/> Trader / Business Owner</td> <td><input type="checkbox"/> Religious Leader</td> <td><input type="checkbox"/> CBO Staff</td> <td><input type="checkbox"/> Other</td> </tr> <tr> <td><input type="checkbox"/> Student</td> <td><input type="checkbox"/> Non-State Armed Actor / Rebel / Militia</td> <td><input type="checkbox"/> Teacher</td> <td><input type="checkbox"/> Community Volunteer</td> <td><input type="checkbox"/> Unemployed</td> </tr> <tr> <td><input type="checkbox"/> Civil Servant</td> <td><input type="checkbox"/> Security Official</td> <td><input type="checkbox"/> UN Staff</td> <td><input type="checkbox"/> Health Worker</td> <td><input type="checkbox"/> Unknown</td> </tr> <tr> <td><input type="checkbox"/> Police</td> <td><input type="checkbox"/> Camp or Community Leader</td> <td><input type="checkbox"/> NGO Staff</td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> State Military</td> <td></td> <td></td> <td></td> <td></td> </tr> </table>		<input type="checkbox"/> Farmer	<input type="checkbox"/> Trader / Business Owner	<input type="checkbox"/> Religious Leader	<input type="checkbox"/> CBO Staff	<input type="checkbox"/> Other	<input type="checkbox"/> Student	<input type="checkbox"/> Non-State Armed Actor / Rebel / Militia	<input type="checkbox"/> Teacher	<input type="checkbox"/> Community Volunteer	<input type="checkbox"/> Unemployed	<input type="checkbox"/> Civil Servant	<input type="checkbox"/> Security Official	<input type="checkbox"/> UN Staff	<input type="checkbox"/> Health Worker	<input type="checkbox"/> Unknown	<input type="checkbox"/> Police	<input type="checkbox"/> Camp or Community Leader	<input type="checkbox"/> NGO Staff			<input type="checkbox"/> State Military				
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<input type="checkbox"/> Police	<input type="checkbox"/> Camp or Community Leader	<input type="checkbox"/> NGO Staff																								
<input type="checkbox"/> State Military																										

5-Planned Action / Action Taken: Any action / activity regarding this report.

Who referred the client to you?* <table border="0"> <tr> <td><input type="checkbox"/> Health/Medical Services</td> <td><input type="checkbox"/> Teacher/School Official</td> </tr> <tr> <td><input type="checkbox"/> Psychosocial/Counseling Services</td> <td><input type="checkbox"/> Community or Camp Leader</td> </tr> <tr> <td><input type="checkbox"/> Police/Other Security Actor</td> <td><input type="checkbox"/> Safe House/Shelter</td> </tr> <tr> <td><input type="checkbox"/> Legal Assistance Services</td> <td><input type="checkbox"/> Other Humanitarian or Development Actor</td> </tr> <tr> <td><input type="checkbox"/> Livelihoods Program</td> <td><input type="checkbox"/> Other Government Service</td> </tr> <tr> <td><input type="checkbox"/> Self Referral/First Point of Contact</td> <td><input type="checkbox"/> Other (specify) _____</td> </tr> </table>		<input type="checkbox"/> Health/Medical Services	<input type="checkbox"/> Teacher/School Official	<input type="checkbox"/> Psychosocial/Counseling Services	<input type="checkbox"/> Community or Camp Leader	<input type="checkbox"/> Police/Other Security Actor	<input type="checkbox"/> Safe House/Shelter	<input type="checkbox"/> Legal Assistance Services	<input type="checkbox"/> Other Humanitarian or Development Actor	<input type="checkbox"/> Livelihoods Program	<input type="checkbox"/> Other Government Service	<input type="checkbox"/> Self Referral/First Point of Contact	<input type="checkbox"/> Other (specify) _____
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Did you refer the client to a safe house/safe shelter?* <input type="checkbox"/> Yes <input type="checkbox"/> No If 'No', why not?* <input type="checkbox"/> Service provided by your agency <input type="checkbox"/> Services already received from another agency <input type="checkbox"/> Service not applicable <input type="checkbox"/> Referral declined by survivor <input type="checkbox"/> Service unavailable	Date reported or future appointment date (day/month/year) and Time: Name and Location: Notes (including action taken or recommended action to be taken):												
Did you refer the client to health / medical services?* <input type="checkbox"/> Yes <input type="checkbox"/> No If 'No', why not?* <input type="checkbox"/> Service provided by your agency <input type="checkbox"/> Services already received from another agency <input type="checkbox"/> Service not applicable <input type="checkbox"/> Referral declined by survivor <input type="checkbox"/> Service unavailable	Date reported or future appointment Date and Time: Name and Location: Follow-up Appointment Date and Time: Notes (including action taken or recommended action to be taken):												

Incident ID

<p>Did you refer the client to psychosocial services?*</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If 'No', why not?*</p> <p><input type="checkbox"/> Service provided by your agency</p> <p><input type="checkbox"/> Services already received from another agency</p> <p><input type="checkbox"/> Service not applicable</p> <p><input type="checkbox"/> Referral declined by survivor</p> <p><input type="checkbox"/> Service unavailable</p>	<p>Date reported or future appointment date (day/month/year) and Time:</p> <p>Name and Location:</p> <p>Notes (including action taken or recommended action to be taken):</p>
<p>Does the client want to pursue legal action?* <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Undecided at Time of Report</p>	
<p>Did you refer the client to legal assistance services?*</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If 'No', why not?*</p> <p><input type="checkbox"/> Service provided by your agency</p> <p><input type="checkbox"/> Services already received from another agency</p> <p><input type="checkbox"/> Service not applicable</p> <p><input type="checkbox"/> Referral declined by survivor</p> <p><input type="checkbox"/> Service unavailable</p>	<p>Date reported or future appointment date (day/month/year) and Time:</p> <p>Name and Location:</p> <p>Notes (including action taken or recommended action to be taken):</p>
<p>Did you refer the client to the police or other type of security actor?*</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If 'No', why not?*</p> <p><input type="checkbox"/> Service provided by your agency</p> <p><input type="checkbox"/> Services already received from another agency</p> <p><input type="checkbox"/> Service not applicable</p> <p><input type="checkbox"/> Referral declined by survivor</p> <p><input type="checkbox"/> Service unavailable</p>	<p>Date reported or future appointment date (day/month/year) and Time:</p> <p>Name and Location:</p> <p>Notes (including action taken or recommended action to be taken):</p>
<p>Did you refer the client to a livelihoods program?*</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If 'No', why not?*</p> <p><input type="checkbox"/> Service provided by your agency</p> <p><input type="checkbox"/> Services already received from another agency</p> <p><input type="checkbox"/> Service not applicable</p> <p><input type="checkbox"/> Referral declined by survivor</p> <p><input type="checkbox"/> Service unavailable</p>	<p>Date reported or future appointment date (day/month/year) and Time:</p> <p>Name and Location:</p> <p>Notes (including action taken or recommended action to be taken):</p>

Intake and Initial Assessment Form

Instructions	1- This form is to be filled out by a case manager, or social worker providing services to the survivor of GBV. Filling out this form is <u>not</u> the equivalent of providing a service.
	2- Note that questions followed by an asterisk* must remain on the intake form and must be answered. These questions are a part of a minimum essential dataset on GBV. Some questions are followed by both an asterisk* and a circle ^o ; these are customizable, and the italicized text of these fields is intended to be adapted to each context and can be modified. Questions that are unmarked may be modified by your agency or removed if they are not necessary for your program and/or case management.
	3- Unless otherwise specified, always mark <u>only one</u> response field for each question.
	4- Please feel free to add as many questions to this form as needed in your context and/or attach additional pages with continued narrative, if needed.

Before beginning the interview, please be sure to remind your client that all information given will be kept confidential, and that they may choose to decline to answer any of the following questions.

1-Administrative Information		
Incident ID*:	Survivor code:	Caseworker code:
Date of interview (day/month/year) *:		Date of incident (day/month/year) *:
<input type="checkbox"/> Reported by the survivor or reported by survivor's escort and survivor is present at reporting* <i>(These incidents will be entered into the Incident Recorder)</i>		
<input type="checkbox"/> Reported by someone other than the survivor and survivor is not present at reporting <i>(These incidents will <u>not</u> be entered into the Incident Recorder)</i>		
2-Survivor Information		
Date of birth (approximate if necessary) *:	Sex*: <input type="checkbox"/> Female <input type="checkbox"/> Male	Clan or ethnicity:
Country of origin ^o : <input type="checkbox"/> Country names here <input type="checkbox"/> Etc.	<input type="checkbox"/> Etc. <input type="checkbox"/> Etc.	<input type="checkbox"/> Other (specify) :
Nationality (If different than country of origin):		Religion:
Current civil / marital status*:	<input type="checkbox"/> Single <input type="checkbox"/> Married / Cohabiting	<input type="checkbox"/> Divorced / Separated <input type="checkbox"/> Widowed
Number and age of children and other dependants:		
Occupation:		
Displacement status at time of report*:		
<input type="checkbox"/> Resident <input type="checkbox"/> Returnee	<input type="checkbox"/> IDP <input type="checkbox"/> Foreign National	<input type="checkbox"/> Refugee <input type="checkbox"/> Asylum Seeker
<input type="checkbox"/> Stateless Person <input type="checkbox"/> Other_____		
Is the client a Person with Disabilities? * <input type="checkbox"/> No <input type="checkbox"/> Mental disability <input type="checkbox"/> Physical disability <input type="checkbox"/> Both		
Is the client an Unaccompanied Minor, Separated Child, or Other Vulnerable Child?*		
<input type="checkbox"/> No <input type="checkbox"/> Unaccompanied Minor <input type="checkbox"/> Separated Child <input type="checkbox"/> Other Vulnerable Child		
Sub-Section for Child Survivors (less than 18 years old)		
If the survivor is a child (less than 18yrs) does he/she live alone? <input type="checkbox"/> Yes <input type="checkbox"/> No (if "No", answer the next three questions)		
If the survivor lives with someone, what is the relation between her/him and the caretaker?		
<input type="checkbox"/> Parent / Guardian <input type="checkbox"/> Relative <input type="checkbox"/> Spouse / Cohabiting <input type="checkbox"/> Other:_____		
What is the caretaker's current marital status?		
<input type="checkbox"/> Single <input type="checkbox"/> Married / Cohabiting <input type="checkbox"/> Divorced / Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Unknown / Not Applicable		
What is the caretaker's primary occupation:		



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