



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.

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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.

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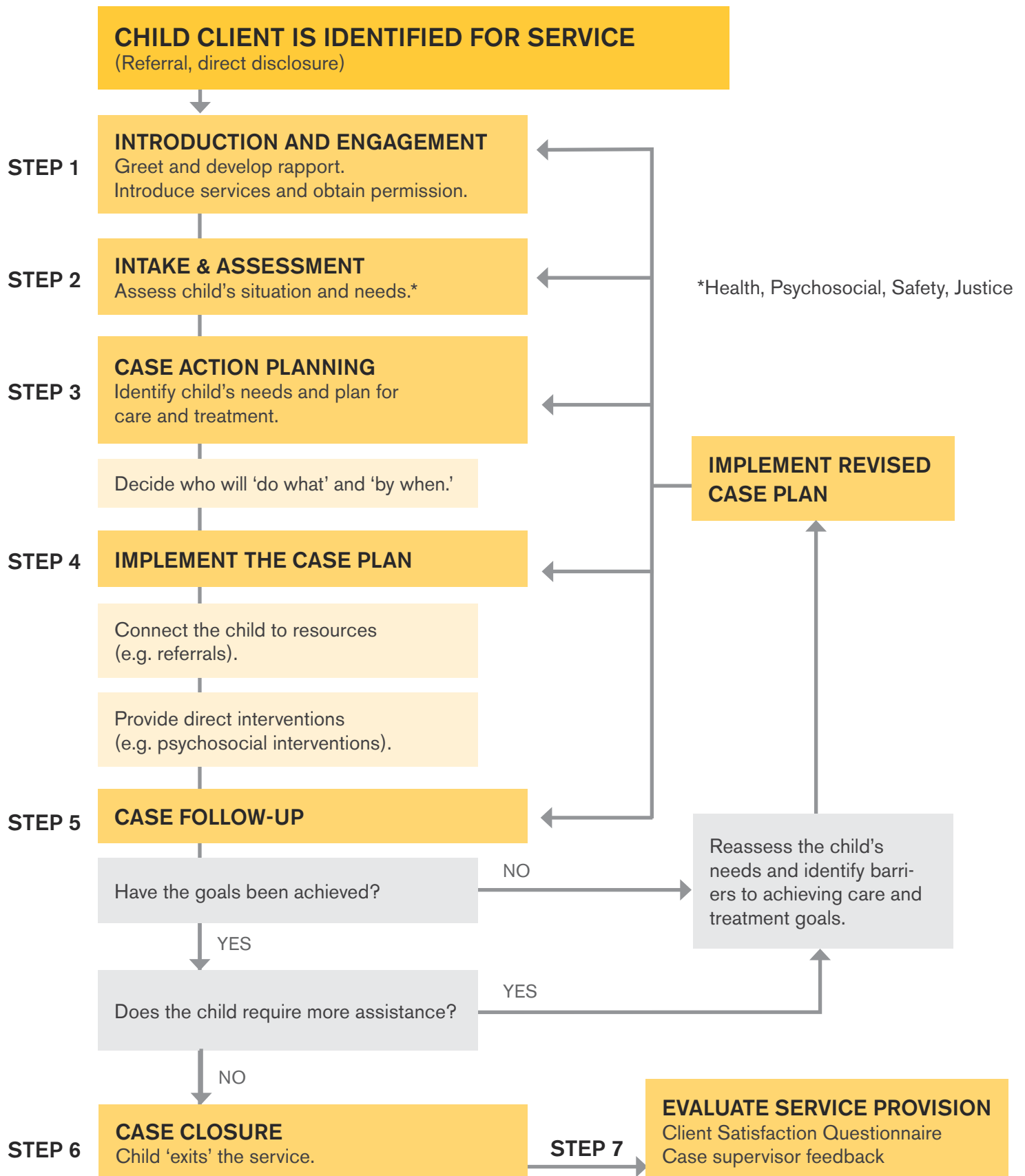
Photo: Gina Bramucci/the IRC

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



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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>.

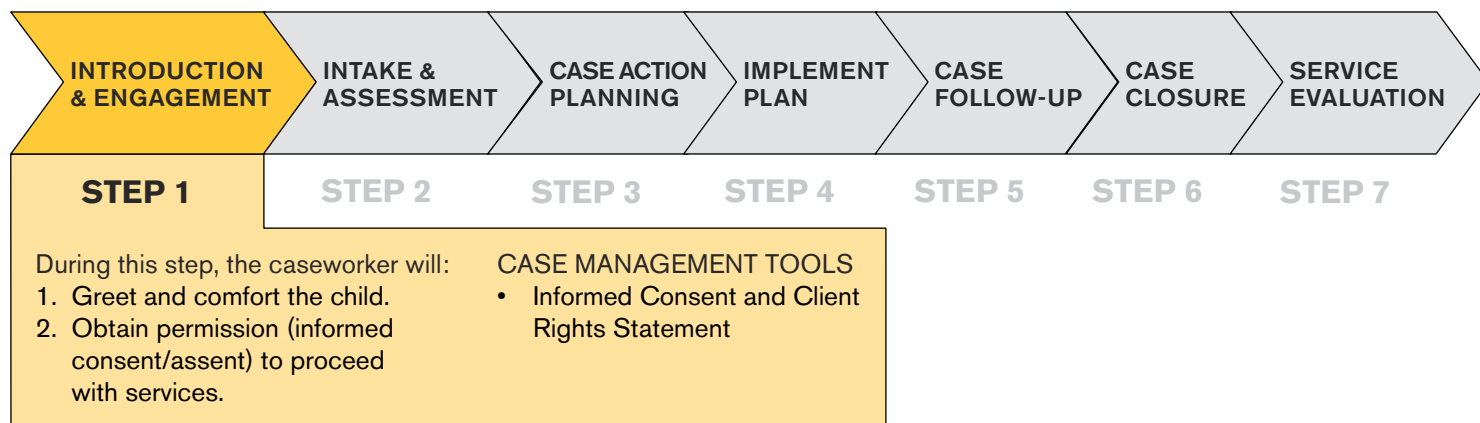
CASE MANAGEMENT STEP	CASE MANAGEMENT TOOLS
STEP 7: SERVICE EVALUATION	<p>Child Client Satisfaction Questionnaire This is an optional tool which can be used in settings that are more stable (e.g., protracted refugee camp contexts and post-conflict settings). Following guidelines, this tool is provided 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/>.

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- » 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.

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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

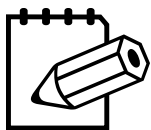
⁶³ Reference **Chapter 4** for more discussion on this key issue. The decision to go against children and/or caregiver's wishes is a serious decision which should be determined, in large part, by the urgency of the child's needs (for example, to secure their immediate safety and/or to mobilize life-saving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

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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?

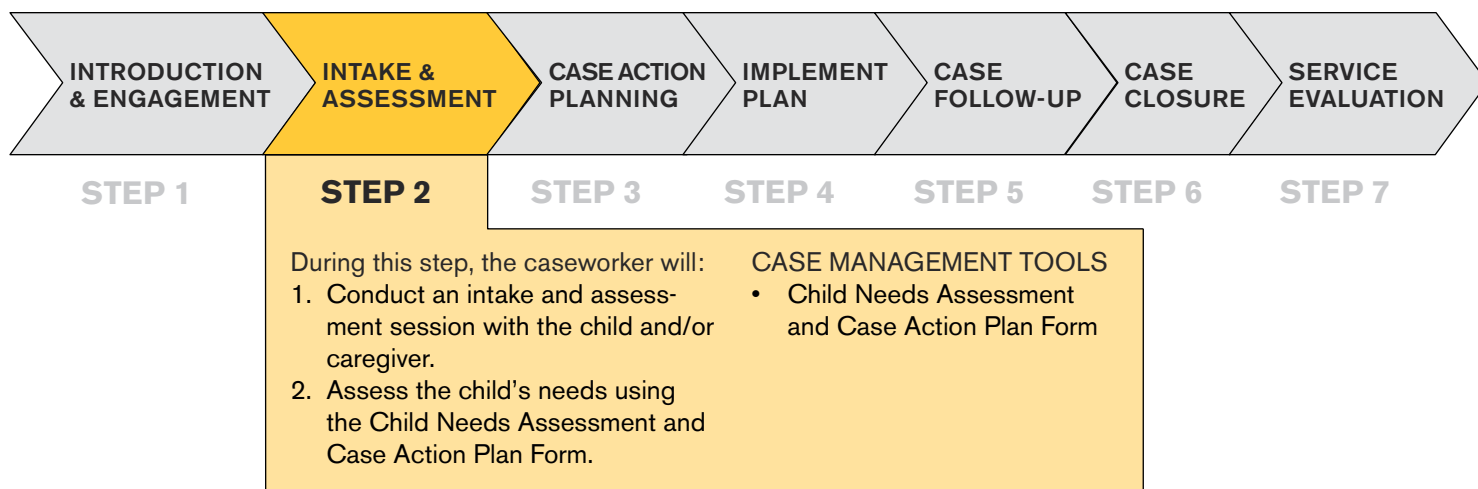
[Allow for time to answer any questions the child and caregiver may have before moving forward to obtain their informed consent/assent to proceed].

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.

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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

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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.

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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

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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)

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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.

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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.

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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).

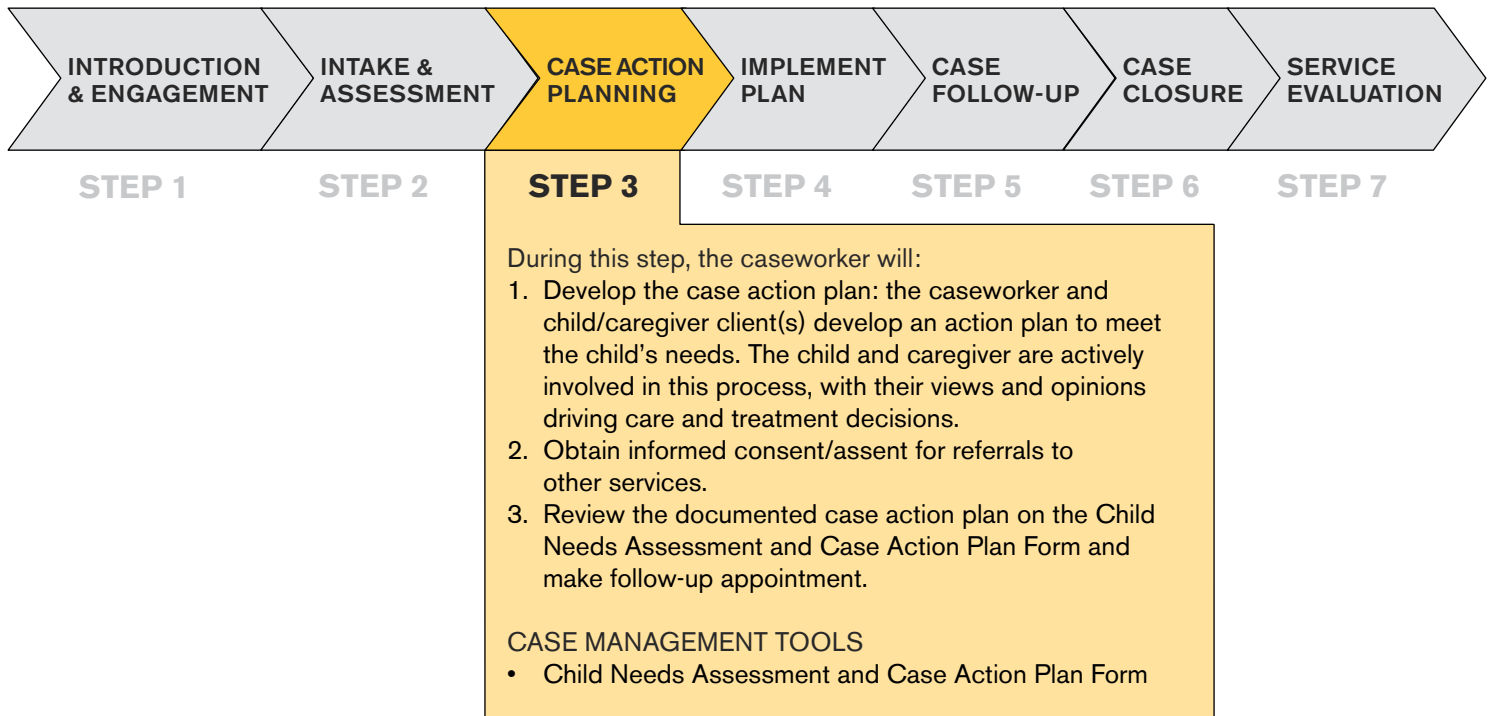
Caseworkers, therefore, need to know the options for pursuing justice in a particular setting. If a legal aid center exists, children and caregivers should be referred to this agency for a full explanation of options. The caseworker can document legal referrals in **Part D: Legal Needs and Assessment**.

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:

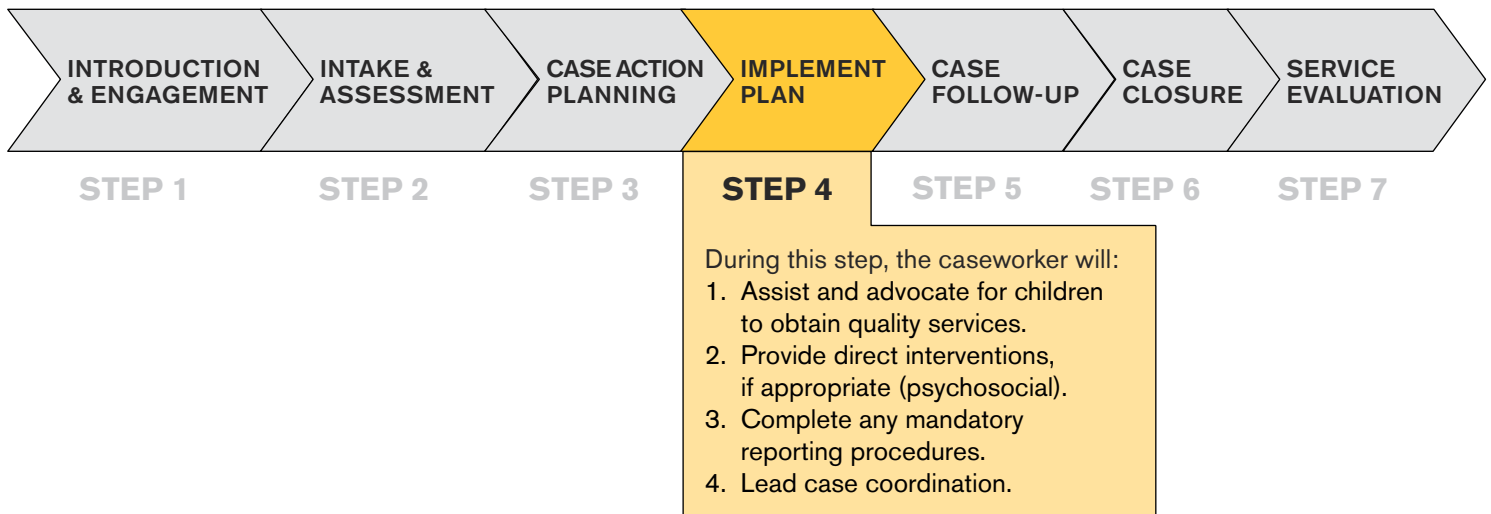
Follow up meeting is scheduled for: Date: _____

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.

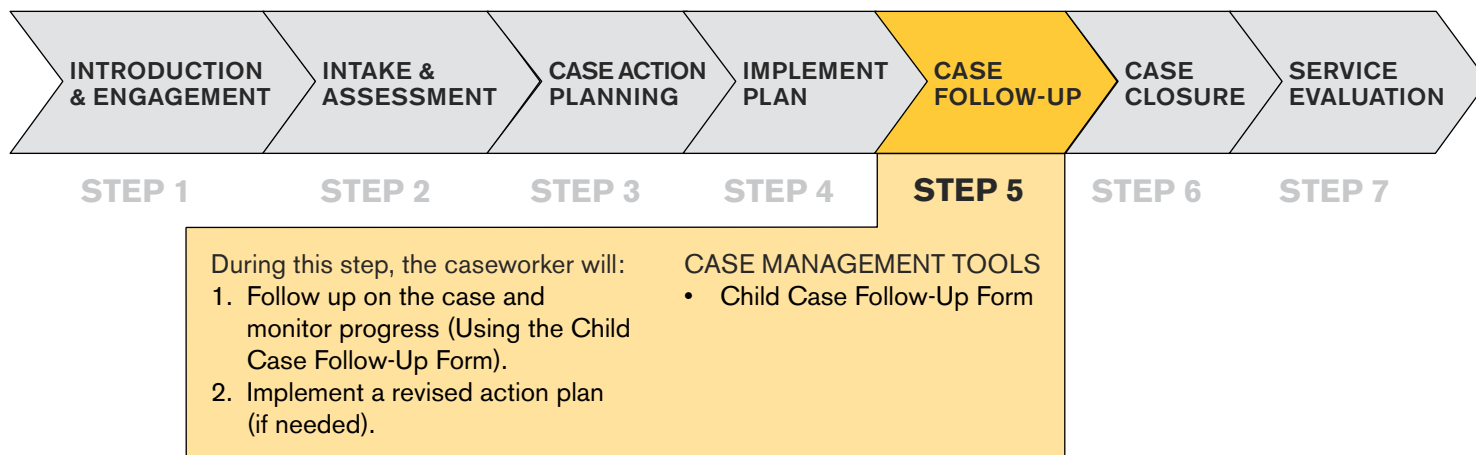
Case conferences are oftentimes scheduled when the child's needs are not being met in a timely or appropriate way. The purpose of the case conference is to gather the appropriate service providers (and concerned support people in the child's life as appropriate) to identify or clarify ongoing issues 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?

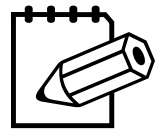
STEP 5: CASE FOLLOW-UP AND MONITORING PROGRESS



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

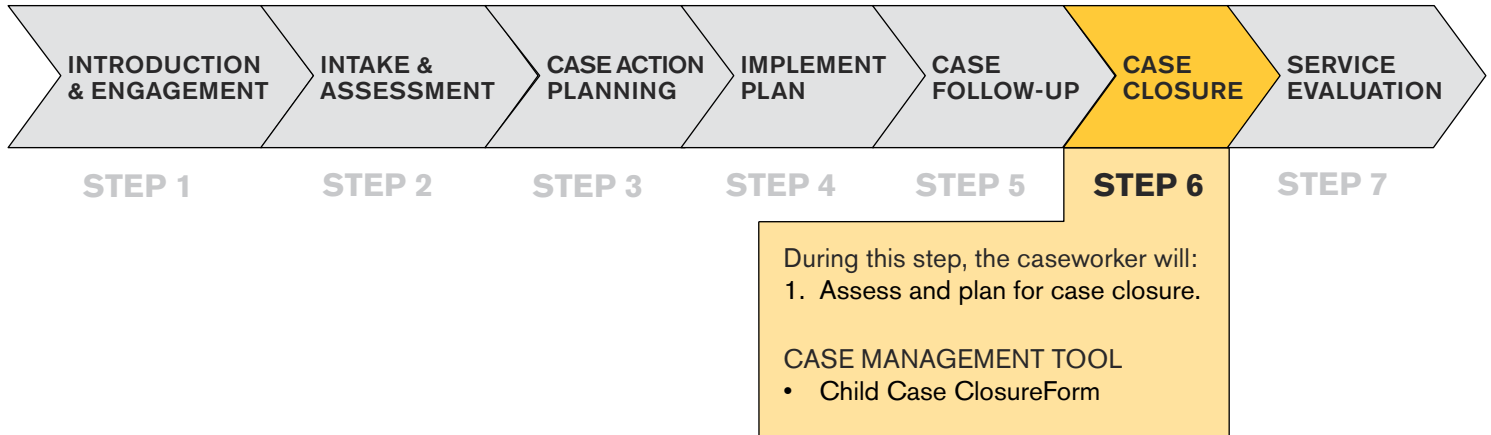
2. IMPLEMENT REVISED CASE ACTION PLAN

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

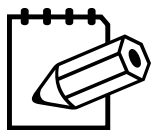
It is important that caseworkers know when their work is finished with children and families affected by sexual abuse. This is not always easy to determine. While the case management process looks linear, service providers need to recognize that children's lives are rarely so straightforward, and most 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

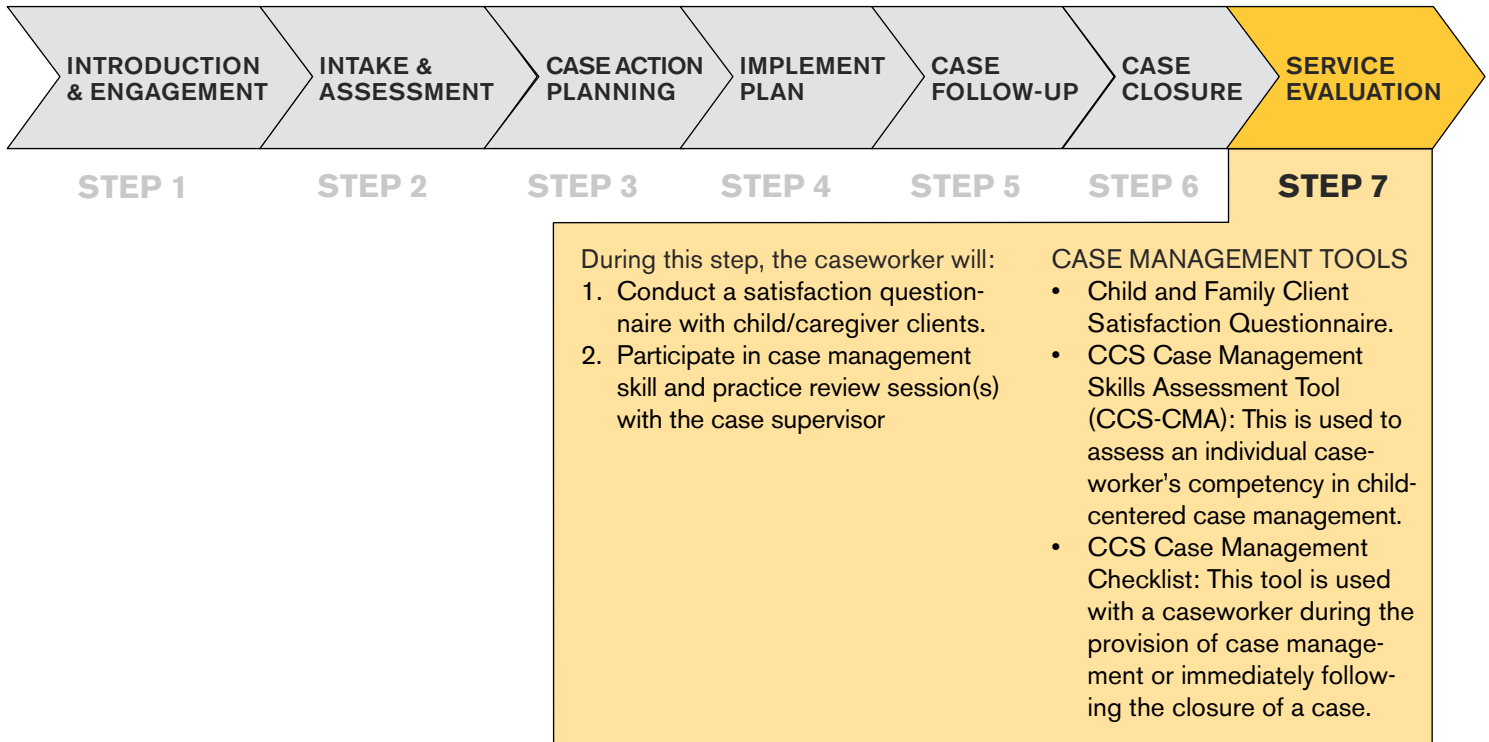
- | | | |
|---|----------|-------------------|
| ✓ Child safety plan has been reviewed and is in place. | Yes_____ | No_____ (explain) |
| ✓ Child/caregiver has been informed she or he can resume services at anytime. | Yes_____ | No_____ (explain) |
| ✓ Case supervisor has reviewed case closure/exit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

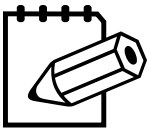
5 CASE MANAGEMENT FOR CHILD SURVIVORS

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

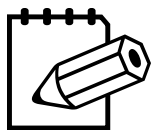
- (1) This supervision tool should be performed through a verbal interview between the staff and his/her supervisor in a quiet and confidential location.
- (2) The supervisor should inform the staff person this tool is being used to assess areas where further capacity building is needed. It is not a 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

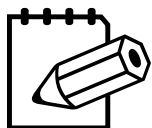
- » The supervisor administering the tool will need to add up the points in each column and then total each column for a final score. Only one score is allowed per question.
- » Final Score:
- **16–20 points: MET** Scores in this range indicate that the staff person has met the core case management requirements 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.				

5. Explained options for service providers to help meet the child's needs.				
6. Ask the child and caregiver how much information they would like to have shared during the referral process and how.				
7. Obtain informed consent/assessment for referrals.				
8. Coordinate the child's needs through safe and appropriate referrals (e.g. Accompany the child).				
9. Implement mandatory reporting procedures (if applicable).				
10. Implement additional psychosocial support your agency offers (if appropriate).				
11. Consult with supervisor on urgent safety concerns raised.				
12. Make a follow up plan/appointment.				
13. Complete the correct forms and documentation.				

CASE FOLLOW UP

Did the case worker...	Yes	No	N/A	Supervisor Comment
1. Meet with the child client at the requested time and location for follow up appointment.				
2. Review the initial case goals and action plan to assess the status of the child's needs being met.				
3. Re-assess the child's needs (focus on safety) during the follow up to see if new issues or needs came up.				
4. Develop a revised action plan to meet new needs the child has.				
5. Obtain informed consent for any additional service providers who will be brought into the child's care and treatment.				
6. Make another follow-up appointment with the child and/or caregiver.				
7. Complete the correct forms and documentation.				

CASE CLOSURE

Did the case worker...	Yes	No	N/A	Supervisor Comment
1. Assess, with the child/caregiver, if all needs have been met and no further case management is needed.				
2. Review safety plan in place.				
3. Explain to the child and caregiver they can always come back for further services.				
4. Complete the appropriate case documentation.				

OVERALL CASE MANAGEMENT PROVIDED

Did the case worker...	Yes	No	N/A	Supervisor Comment
1. Follow the CCS Guiding Principles				
2. Complete case management steps and procedures according the CCS				
3. Receive advice and supervision from her case management supervisor well				