GLOBAL CARING FOR CHILD SURVIVORS' SUPERVISION SUPPORT: COACHING MANUAL

VERSION FOR PILOTING

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INTRODUCTION

This *Global Caring for Child Survivors Supervision Support Coaching Manual* has been developed to strengthen supervisory practice by providing structured guidance, practical tools, and standardized approaches to coaching and support for supervisors of caseworkers managing cases of child survivors of sexual abuse. It responds to the need for supervisors to translate training content from the Second Edition of the *Caring for Child Survivors of Sexual Abuse Guidelines*[1] (CCS) and associated training package into sustained, high-quality practice while ensuring alignment with organizational standards and global guidance.

Effective supervision is essential to maintaining the quality, consistency, and impact of case management and other frontline GBV/CP services for child survivors of sexual abuse (referred to as child survivors in this manual). While training equips caseworkers with foundational knowledge and skills, ongoing supervision and coaching are critical to reinforcing learning, supporting application in real-world contexts, and professional development.

The objectives of this manual are to:

- Support supervisors to provide consistent, high-quality supervision to caseworkers
- Reinforce and operationalize key concepts, competencies, and practices introduced through prior CCS Training of Trainers (ToTs), including CCS-trained caseworkers
- Promote reflexive practice[2], problem-solving, and skills development through structured coaching and supervision
- Serve as a practical reference for planning, delivering, and documenting supervision and coaching activities

This manual is primarily aimed at:

- Supervisors, team leaders, and managers responsible for providing technical and supportive supervision to caseworkers supporting child survivors.

While the primary users are supervisors, the manual may also be useful to:

- Program managers seeking to standardize supervision approaches
- Country office staff adapting and contextualizing supervision systems
- Trainers facilitating refresher training or follow-up support

Users are encouraged to integrate the tools and guidance into existing supervision structures rather than treating the manual as a standalone or one-off resource.

[1] UNICEF & IRC (2023). Caring for Child Survivors of Sexual Abuse Guidelines, Second Edition. UNICEF, New York.

[2] Reflexive meaning capable of reflection. The coaching process and manual provide an opportunity for caseworkers to tune into /look back on how they have been conducting case management with child survivors and offer an opportunity for them to reflect on how to further strengthen their practice.

Gender-based violence and child protection actors are the key focus of this manual. Health actors, including MHPSS actors and other related humanitarian actors may also find the CCS package, and this coaching manual beneficial to advancing survivor-centered practice.

When should the manual be used?

This manual will be of optimal benefit:

- Following completion of relevant ToTs or formal training packages
- When used during routine supervision cycles (e.g., monthly or quarterly supervision)
- When onboarding new supervisors or coaches
- As part of refresher or continuous professional development activities
- When addressing performance challenges or supporting skill enhancement

Linkage to Prior Guidance and Trainings:

This manual aligns with, and should be used in conjunction with, the Second Edition of the *Caring for Child Survivors of Sexual Abuse Guidelines* and training package, maintaining fidelity to core principles, standards, and competencies. It builds directly on prior CCS ToTs, including those for CCS-trained caseworkers, and is intended to support the practical application of that training in day-to-day work.

All terms used here align with the definitions put forward in the *Caring for Child Survivors of Sexual Abuse Guidelines* glossary which can be referred to for more detailed insight.

Pilot Use and Contextualization:

This manual is being issued as a pilot version for initial use by UNICEF country offices. Country teams are encouraged to contextualize the content to reflect local systems, roles, terminology, and operational realities, while maintaining fidelity to the core guidance and intent of the Second Edition of the *Caring for Child Survivors of Sexual Abuse Guidelines* and training package. Feedback from country-level implementation will inform future revisions and refinements of the manual.[3]

OVERVIEW

Overall, there are 11 coaching sessions featured in this manual. They are presented here in a sequential order but can be rearranged based on the needs of the caseworkers under supervision. Supervisors are advised to review the session content beforehand to aid delivery and make adaptations where necessary.

Each session has a summary table providing a top-level description of what will be covered, the materials needed, and suggested timings for delivery. Below this, supervisors will find

[3] Subject to resources being available.

the full session content, including delivery prompts to guide the session, which are as follows:

- **SAY** indicates language that should be delivered word-for-word to ensure clarity, consistency, and fidelity to the module content; supervisors are encouraged to use the exact phrasing provided.
- **EXPLAIN** signals that the content conveys key concepts or guidance that supervisors should understand thoroughly and restate in their own words, adapting naturally to the context while preserving the core meaning.
- **ASK** introduces a specific question, typically to prompt reflection, assessment, or dialogue.
- **DO** indicates a specific activity, practice exercise, or observable action that supervisors and/or supervisees are expected to complete.
- **DISCUSS** directs supervisors to engage in a two-way conversation about the topic, encouraging shared reflection, clarification, and exploration of perspectives.
- **CONFIRM** directs supervisors to verify understanding, agreement, or next steps so that expectations are clear and aligned before moving forward.

These coaching sessions are designed primarily for delivery in a group setting, where discussion, shared learning, and peer reflection enhance the experience. However, the content and activities can be readily adapted for individual coaching sessions. Supervisors should adjust discussion prompts, activities, and timing as needed to suit a one-on-one format while maintaining the core objectives and learning outcomes of each session.

Session No.	Brief description
Session 1: Introduction to the coaching process & CCS Guiding Principles	Introduces the coaching approach, structure, and expectations, while grounding participants in the core guiding principles of CCS. The session reinforces self-/collective-care and supports reflection on applying CCS principles in practice through discussion and case studies.
Session 2: Child-friendly attitudes in case work	Strengthens participants' understanding of child-friendly attitudes and their critical role in effective CCS case work. The session promotes reflective practice on how attitudes influence interactions and decision-making with child survivors.
Session 3: Communication Skills	Reinforces the importance of positive, child-friendly communication skills, including active listening, verbal and non-verbal communication, and the use of healing statements. Participants reflect on successes and challenges and practice applying skills across stages of the case management process.
Session 4: Inclusive communication techniques	Builds participants' capacity to apply age-appropriate, developmentally suitable, and inclusive communication techniques, including when working with children with

	disabilities. The session focuses on adapting directive and non-directive approaches to diverse needs and contexts.[4]
Session 5: Complexities relating to case management steps and process	Explores key complexities that may arise during CCS case management. Participants engage in reflexive practice and case studies on selected priority challenges.
Session 6: Complexities relating to case management steps and process	Continues exploration of complex case management issues not addressed in Session 5. Participants engage in reflexive practice and case studies on selected priority challenges.
Session 7: MHPSS assessment	Strengthens understanding of effective MHPSS assessment for child survivors, with particular attention to using the MHPSS assessment tool. Participants practice using the tool and identifying MHPSS needs.
Session 8: High risk/ complex MHPSS assessment	Builds participants' skills in addressing high risk/ complex cases, including suicide and self-harm. The session reinforces non-judgmental support, referral pathways, and supervision approaches for high-risk cases.
Session 9: Case-level Coordination	Reinforces the importance of safe referrals, effective coordination, and appropriate use of case consultations and case conferences. Participants identify practical strategies to strengthen coordination while upholding CCS guiding principles within their operational context.
Session 10: Working with non-offending caregivers	Strengthens participants' understanding of when and how to engage non-offending caregivers in line with the CCS Guidelines, including coordination considerations. The session supports reflexive practice on current approaches and identifies strategies to strengthen caregiver engagement to improve outcomes for child survivors.
Session 11: Key learnings summation/ closing session	Provides an opportunity to consolidate learning from the coaching program, reflect on practice improvements, and address remaining questions. The session also gathers participant feedback to inform refinement of the coaching manual and approach.

[4] Directive communication involves providing clear structure, guidance, or information to support understanding and safety. Non-directive communication allows the child to lead the pace and content of the interaction, supporting autonomy and emotional safety; these can be verbal and non-verbal.

PREPARATION GUIDANCE FOR SUPERVISORS

This section briefly outlines the general objective of the delivery of coaching support for supervisors – what it is and what it is not - and provides tips for how supervisors can prepare effectively for coaching sessions.

Objective: The purpose of providing coaching support to GBV/CP caseworkers is to enhance their capacity to support child survivors and apply technical knowledge (including guiding principles and guidelines) and enhance their communication skills and promote child-friendly attitudes.

Coaching support is not a space for line management or performance-related discussions. These discussions should take place separately.

Tips
Read through this coaching manual before delivering it to ensure you understand the content and can adapt it appropriately to your context. If you need a refresher on any topics, consult the CCS Second Edition of the Guidelines and Training Package, along with the resources included in this manual, to ensure you are prepared to coach supervisees effectively and competently.
Think carefully about whether a group or an individual coaching support session is going to be most beneficial for your supervisee(s). Think about the level of experience your supervisee(s) have and the types of cases they have had successful outcomes with and the types of cases where they may benefit from more guidance, supervision and technical support.
Recognize that caseworkers of all levels of experience may benefit from coaching supervision. Coaching is not only for newly trained caseworkers; experienced caseworkers can benefit too. It can refresh their knowledge and skills and support them in recommitting and renewing their professional dedication to caring for child survivors. All caseworkers can benefit from the peer exchange and mutual learning which comes from group learning if you are using a group coaching format.
Prepare a schedule for when you will deliver the coaching sessions and consult with your supervisee(s) to cross-check that the planned schedule does not conflict with other key activities (e.g., pre-scheduled case management sessions with survivors) AND gives the supervisee(s) sufficient time to prepare for each session.
Ensure you have prepared any relevant visual aids or hand-outs for your supervisee(s) ahead of the session.
Select a location for the sessions that is confidential and conducive to creating a safe, supportive learning environment.
Make sure you dedicate the session solely to your supervisee(s) without other distractions. If an emergency issue arises, then excuse yourself from the session and reschedule it for another time that is mutually convenient, as soon as possible.

Join and start sessions on time to demonstrate respect for everyone's schedule. Also respect the time your supervisee(s) have available. If sessions need longer than the allocated time consult with your supervisee(s) as to whether a) it is feasible to extend session(s) duration or b) it is necessary to schedule an extra session.

PREPARATION GUIDANCE FOR CASEWORKERS

This section briefly outlines for caseworkers (supervisees) the general objective of coaching support – what it is and what it is not, how they may benefit from it and how they should prepare and 'show-up' for coaching sessions to optimize benefits from the sessions.

Objective: The purpose of coaching support for GBV/CP caseworkers is to enhance their capacity to support child survivors and apply technical knowledge (including guiding principles and guidelines) and enhance their communication skills and promote child-friendly attitudes.

Coaching support is not a space for line management or performance-related discussions. These discussions should take place separately.

Tips
Approach the coaching sessions with an open mind and willingness to engage. If you do this, you are likely to benefit from sessions far more.
Try to make time for the pre-session activities. Completing them to the best of your ability will allow your supervisor to support you better.
Try not to bring line management issues into the coaching space, unless it has a very clear link to casework and clearly impacts your technical practice. The coaching space is a space to center child survivors and to grow your skills, knowledge and ability to help them receive timely, quality services that promote safety and healing.
If you are participating in one-to-one coaching sessions with your supervisor, recognize this as an opportunity and benefit to have dedicated space to advancing your practice. Show up ready to engage and have meaningful dialogue with your supervisor.
If you are participating in group coaching sessions, recognize that this is an opportunity and benefit to have both a dedicated learning space for advancing your practice and to learn and exchange with your colleagues. Even the most experienced caseworkers can benefit from a group learning space, if they approach it with a positive attitude, commitment to learning and openness to participate in dialogue.
Respect the schedule and the efforts of your supervisor. Show up for sessions on time. If you are delayed due to an emergency or are unable to attend a session, make sure you notify your supervisor as soon as possible.

Make sure you dedicate yourself for the full duration of each session. Try to minimize distractions so that you can be fully present. If there is an emergency with a case that comes up during a session, inform your supervisor immediately and agree to a) briefly pause the session while you deal with the issue b) reschedule the session for another time. An emergency is a life-threatening situation or a situation where a person is at risk of serious harm.

PRE-COACHING LEARNING FOR CASEWORKERS

Before participating in coaching sessions, caseworkers should have attended a CCS training prior.

Depending on how much time has passed since they attended a CCS training, caseworkers may also benefit from taking an online e-learning refresher course which aims at providing the foundational knowledge on Caring for Child Survivors of Sexual Abuse (CCS) based on the 2023 Guidelines. The CCS e-learning course can be accessed via UNICEF's AGORA e-learning platform.

COACHING SESSIONS

SESSION 1: INTRODUCTION TO COACHING PROCESS & CCS GUIDING PRINCIPLES

<table>
<tr><td>Session objectives</td><td>To introduce the coaching process and format to participants.
To re-cap and ground participants in the guiding principles of CCS.</td></tr>
<tr><td>Session Duration:</td><td>60 minutes</td></tr>
<tr><td>Session content overview and recommended timings</td><td>Welcome and introductions ((5 mins)
Coaching process, objectives and structure (5 mins)
Re-cap of importance of self-/collective- care (10 mins)
Objective and gain participant insights/ experience
Example of a self-care exercise
Re-cap of CCS Guiding principles (30 mins)
Discussion activity and/or Case study practice
Debrief (5 mins)
Session wrap-up (5 mins)</td></tr>
<tr><td>Session materials</td><td>Handouts
CCS Module 1 handout: Guiding Principles of the Caring for Child Survivors Approach
Case Study: Applying the CCS Guidelines in Practice
Session insights/evaluation form</td></tr>
<tr><td>Pre-session reflection / activity for caseworkers</td><td>N/A</td></tr>
<tr><td>Optional Post-Session Reading</td><td>Chapter 1 of the CCS Guidelines (pages 20-25)
Module 1 of CCS training package
Handout 1.1 Guiding Principles of the Caring for Child Survivors Approach</td></tr>
</table>

Session 1 content

1.1 Welcome and introductions *(5 minutes)*

- Welcome the participants to the coaching session
- **SAY** coaching sessions are safe learning sessions where questions and inputs are welcome to support growth and learning
- **ASK** participants to share their name, role, and something they are looking forward to from the coaching sessions

DO Optional exercise: Two truths and a lie

If the participants do not know one another, or do not work with one another frequently, it can be helpful to have an ice breaker exercise for participants to get to know one another.

- Pair up participants
- Tell the participants to prepare 3 statements each: two true statements and one lie - these can be about the person, their job, their preferences, anything!
- Participants then take it in turn to share their statements with their partner; one participant has shared their two truths and one lie, their partner has to guess which of the three statements was a lie

1.2 Coaching process, objectives and structure *(5 minutes)*

- **SAY:** This coaching process is designed to support you, as a caseworker, to strengthen your CCS practice through structured, participatory group sessions that reinforce key principles, build practical skills, and provide space for reflection and peer learning.

There are 11 coaching sessions in total, each one hour long – although we may take longer if there is scope and need to extend session durations to support effective learning. We will aim to have sessions on a reasonably frequent basis to maintain learning momentum and support learning being converted to practice and retention of knowledge. For example, fortnightly or monthly sessions, if feasible. Each session links to content from the CCS Guidelines, allowing us to review how we have incorporated the guidelines into practice, any challenges, or ongoing questions since the CCS training.

1.3 Re-cap of importance of self-/collective- care *(10 minutes)*

- **SAY:** Working with child survivors of sexual abuse places significant emotional, psychological, and ethical demands on caseworkers and supervisors. The CCS Guidelines recognize that sustained exposure to survivors' experiences of trauma can

place staff at risk of stress, burnout, vicarious trauma and negatively impact their wellbeing, which can in turn affect the quality, safety, and consistency of care provided to children and their non-offending caregivers.

EXPLAIN what self, collective care and wellbeing mean:

- **Self-care**: Self-care is the ongoing practice of tending to your physical, emotional, mental, and spiritual well-being through intentional actions that sustain your energy, resilience, and sense of wholeness. It's not an escape from responsibility but a way of resourcing yourself so you can show up with clarity, presence, and integrity. It includes practices that help you regulate your nervous system, honor your boundaries, and stay connected to your values, whether that's rest, reflection, movement, creativity, or asking for support.
- **Collective care:** Collective care is the shared responsibility of supporting the wellbeing of a group or community. It recognizes that no one thrives in isolation and that care is strengthened when it's mutual, relational, and embedded in the culture of a team or community. Collective care includes practices that create safety, belonging, and sustainability for everyone, such as shared norms, emotional check-ins, equitable workloads, community agreements, and systems that reduce burnout and foster connection.
- **Wellbeing: "**Wellbeing is a state where an individual or group feels balanced and at peace in body, mind and soul. Well-being is realized when we are able to acknowledge the conditions of our lives including aspects that may be unfair, and yet also nurture dreams and take decisions to change or improve these conditions without harboring anger." (*Strategies for building an organisation with a soul, Hope and Rudo Chigudu, 2015*).

Self- and collective care are therefore essential components of quality CCS implementation. Self-care supports individual caseworkers to recognize their own limits, regulate stress, and maintain emotional wellbeing, while collective care promotes shared responsibility within teams to create supportive, reflective, and safe working environments.

DISCUSS:

- What are some examples of self-care that you practice as an individual?
- What are some examples of collective care that you practice as a team?
- How do you feel after your self-/ collective-care activity?
- Are there any barriers to implementing (more) self-/ collective-care into your work?

Throughout the coaching sessions, we will be practicing self and collective care exercises, which are both useful to you as caseworkers, but can also be adapted and made relevant to your work with clients.

DO: Example of a self-care exercise: Box Breathing Exercise

- Ask participants to sit comfortably and close their eyes.
- Take a deep breath in through your nose, allowing your belly to expand. Hold your breath for a few seconds, and then exhale slowly through your mouth. Repeat this several times to help distract your thoughts from the stressor and allow your body to relax.
- Introduce the box breathing exercise. Box breathing, also known as square breathing, is a deep breathing technique that can help you relax and manage stress. It's named after the box shape created by the four steps of the exercise:
- Inhale slowly to a count of four
- Hold your breath for a count of four
- Exhale slowly and steadily through your mouth for a count of four
- Hold your breath again for a count of four
- After a few rounds of box breathing, ask participants to slowly return to their normal breathing rhythm, and invite them to slowly open their eyes again

1.4 Re-cap of CCS Guiding principles *(30 minutes)*

- **SAY:** The CCS approach is grounded in guiding principles drawn from best practice in child protection and gender-based violence case management. These principles shape how caseworkers and supervisors engage with child survivors and their non-offending caregivers.
- Before discussing further, **ASK:** from what you can remember, what are the CCS Guiding principles?
- Once answered, share *CCS Module 1 handout: Guiding Principles of the Caring for Child Survivors Approach.*

EXPLAIN: In summary, the CCS Guiding Principles are:

- Treat every child FAIRLY and EQUALLY
- Show EMPATHY, respect, and kindness to child survivors
- Prioritize the SAFETY of the child survivor
- Seek INFORMED ASSENT/INFORMED CONSENT before providing services
- Ensure CONFIDENTIALITY of services
- Facilitate meaningful PARTICIPATION of child survivors
- Build upon STRENGTHS, resources, and coping mechanisms unique to each child survivor
- Promote the BEST INTERESTS of child survivors
  Understand each child's social identities and individual experiences.

DO: Supervisors should facilitate a discussion of the guiding principles, using the group discussion table to prompt reflection and engagement. This activity may be completed prior to the case study, or if the group has a strong grasp of the guiding principles, move directly to the case study activity.

DISCUSS: Use the following table to discuss the CCS Guiding Principles, and how caseworkers apply them in their work.

Guiding Principle	Goal of discussion	Prompts for discussion
Safety and Best Interests of the Child	Help caseworkers reflect on how they prioritize children's physical and emotional safety and make decisions that promote the best interests of the child, particularly when cases are complex or involve competing risks.	• What does "safety" look like in this context from a child's perspective? • What risks and protective factors did you consider when making decisions as a caseworker? • How do we, as a group, decide what the least harmful option is in difficult situations?
Informed Consent, Assent, and Confidentiality	Strengthen understanding of consent, assent, and confidentiality, including how these principles are explained to children and caregivers and how they are managed in challenging contexts.	• How do we explain consent or assent to children of different ages? • What situations make confidentiality difficult to uphold in our context? • How do we communicate limits to confidentiality in ways that remain child-friendly and respectful?
Meaningful Participation	Support caseworkers to examine how children and non-offending caregivers are meaningfully involved in decisions, while recognizing differences in age, development, disability, and power dynamic	• In what ways have you involved children in decisions about their cases? • What helps children participate more meaningfully, and what gets in the way? • How do power dynamics (within families or services) affect participation of children?
Non-Discrimination,	Reflect on respectful, non-judgmental practice and create space to explore how personal reactions, stress, or contextual	• What does respectful and empathetic practice look like in our daily work?

Respect, and Empathy	norms may influence interactions with children and caregivers.	• Are there situations where it is harder to remain non-judgmental? Why? • How can we support one another as a team to uphold these principles?
Strengths-Based and Individualized Practice	Encourage caseworkers to move beyond problem-focused approaches and recognize children's and families' strengths, resilience, and coping strategies.	• What strengths have we seen children or caregivers draw on during case management? • How do we intentionally build on strengths during case management? • How can focusing on strengths help restore a child's sense of control and dignity?
Reflective Practice, Bias, and Collective Care	Normalize reflection on attitudes, biases, and emotional impact, and promote collective care within the team.	• What types of cases affect us most emotionally / psychologically, and why? • How do our own beliefs or community norms influence our work? • What collective strategies can we use to support each other and reduce stress or burnout?

DO: Case Study: Applying the CCS Guiding Principles in Practice

Purpose of the Activity

This activity helps participants apply the Guiding Principles to a complex child protection case. It strengthens critical thinking, ethical decision-making, and child-centered practice.

Instructions

- Ask everyone to read the scenario individually
- Discuss one question under each Guiding Principle (in small groups or as a full group).

Scenario (Used for Both Roleplays)

Amina is a 13-year-old girl who was referred to your services after disclosing sexual abuse by her maternal uncle, who lives in the same household. Amina lives with her mother and two younger siblings. The mother believes Amina but is fearful of reporting the abuse due to concerns about family conflict, stigma, and loss of financial support, as the uncle contributes to household income.

During the initial case meeting, Amina says she does not want anyone outside the family to know what happened and asks the caseworker not to tell her mother everything she shared. She appears anxious and avoids eye contact but engages when spoken to gently. The mother asks the caseworker what actions will be taken and whether the uncle will be removed from the home.

In this context, mandatory reporting requirements exist, but caseworkers report that referrals to authorities sometimes increase risk for children if not carefully managed. There are limited safe shelter / alternative accommodation options in the area, and the caseworker feels pressure to act quickly to ensure Amina's safety while also respecting her wishes.

Discuss one question per Guiding Principle:

Safety and Best Interests of the Child

- What immediate and longer-term safety risks can you identify for Amina?
- What actions would be likely to promote Amina's best interests in this situation?

Informed Consent, Assent, and Confidentiality

- What information can and cannot remain confidential in this case?
- How should the caseworker explain limits to confidentiality to Amina in a child-friendly way?

Meaningful Participation

- How can Amina be meaningfully involved in decisions about her care, given her age and emotional state?
- How can the mother be involved while respecting Amina's wishes?

Non-Discrimination, Respect, and Empathy

- How should the caseworker respond to Amina's fears and the mother's concerns without blame or judgement?
- What attitudes or assumptions might unintentionally cause harm?

Strengths-Based and Individualized Practice

- What strengths or protective factors does Amina possess? What strengths or protective factors are present within her family?
- How can these strengths be built upon in safety planning and case management?

Reflective Practice and Awareness of Bias

- What aspects of this case might be emotionally challenging for a caseworker?
- How could supervision support ethical decision-making in this situation?

1.5 Debrief *(5 minutes)*

- **ASK** if there are any reflections about the Guiding Principles that they would like to share before closing
- Close the session by summarizing key reflections, reinforcing links to the CCS Guiding Principles, **EXPLAIN:**
  - CCS guiding principles are interconnected and may sometimes feel in tension.
  - Emphasize that supervisors are available to support navigating these complexities while maintaining a child-centered, ethical, and survivor-centered approach.
  - Practicing self- and collective care can also help to create supportive, reflective, and safe working environments to implement and seek feedback on practicing the CCS Guiding Principles
- **ASK** each participant to share one reflection from the session that has stood out most to them/ that they will carry with them.

1.6 Session wrap-up *(5 minutes)*

- **ASK** participants to complete the session insights/ evaluation form
- **EXPLAIN** the activity caseworkers will need to complete ahead of the next session: CCS Attitude Assessment
- The activity is the CCS Attitude Assessment, a tool which allows supervisors to determine if a caseworker demonstrates a child-centered attitude that suggests they will provide compassionate and appropriate care and treatment to child survivors. The supervisor will collect these, and review the results with the caseworkers on an individual basis.
- **CONFIRM** date and time of session 2

SESSION 2: CHILD-FRIENDLY ATTITUDES IN CASE WORK

<table>
<tr><td>Session objectives</td><td>To give participants a clear understanding of the importance and necessity of child-friendly attitudes when working with child survivors.
To provide an opportunity for reflexive practice on applying a child-friendly attitude.</td></tr>
<tr><td>Session duration</td><td>60 minutes</td></tr>
<tr><td>Session content overview and recommended timings</td><td>Welcome (10 mins)
Self-care exercise
What is a child-friendly attitude? (5 mins)
The importance of caseworker attitudes
What does having a child friendly attitude look like in practice (25 mins)
Reflection & Role play
Coordination implications (10 mins)
Debrief (5 mins)
Session wrap-up (5 mins)</td></tr>
<tr><td>Session materials</td><td>Handouts
Roleplay script
Session insights/evaluation form</td></tr>
<tr><td>Pre-session reflection / activity for caseworkers</td><td>CCS Attitude Assessment for supervisees to complete and send to their supervisor well ahead of the session for their review.
Supervisors should review the assessments from their supervisees ahead of session and review common themes / issues to discuss and address.</td></tr>
<tr><td>Optional Post-Session Reading</td><td>Chapter 3 of the CCS Guidelines (pages 58-70)
Module 3 of CCS training package</td></tr>
<tr><td></td><td>Chapter 4 of the CCS Guidelines (pages 71 – 91)
Module 4 of CCS training package
Module 4 Handout – Communication Do’s and Don’ts</td></tr>
</table>

Session 2 content

2.1 Welcome *(10 minutes)*

- Welcome the participants to the coaching session.
- **SAY** coaching sessions are safe learning sessions where questions and inputs are welcome to support growth and learning.
- **ASK** how participants have felt since the last session, if there are any questions or reflections from the previous session that they would like to ask/share.
- **EXPLAIN** that today's session will focus on child-friendly attitudes, and confirm everyone understands what is meant by an attitude. If necessary, share the definition from the CCS guidelines:
    - Definition: "Across societies and cultures there are often deeply embedded values and beliefs about children and child sexual abuse that serve to implicitly condone perpetration and silence and shame survivors. Caseworkers, whether consciously or subconsciously may hold some of these harmful values and beliefs, and then these influence the way in which they work with a child survivor of sexual abuse. Values and beliefs – which comprise a service provider's attitudes – have a direct impact on a child's likelihood of disclosing sexual abuse and the child's pathway to healing and recovery." [5]
- Today's session will focus on the importance and necessity of child friendly attitudes when working with child survivors and provide an opportunity for reflexive practice on applying a child-friendly attitude.
- The pre-session activity was the CCS Attitude Assessment, a tool which allows supervisors to determine if a caseworker demonstrates a child-centered attitude that suggests they will provide compassionate and appropriate care and treatment to child survivors. The supervisor will collect these, and review the results with the caseworkers on an individual basis.

DO Self-care exercise: Gratitude Scavenger Hunt

Ask participants to find a physical object in their immediate surroundings that brings them joy, makes them feel thankful, or represents something they are grateful for.

If participants feel comfortable doing so, ask them to show their object and share why they chose it, including what it represents.

2.2 What is a Child-Friendly Attitude? *(5 minutes)*

EXPLAIN that child-friendly attitudes reflect how caseworkers think, feel, and behave when working with child survivors. The CCS Guidelines emphasize that beyond technical skills, the

[5] UNICEF & IRC (2023). *Caring for Child Survivors of Sexual Abuse Guidelines, Second Edition. page 58*. UNICEF, New York.

attitudes held by caseworkers directly influence whether children feel safe, believed, respected, and supported throughout the case management process.

Child-friendly attitudes are grounded in respect for children's dignity, recognition of their evolving capacities, and a commitment to doing no harm. They require caseworkers to approach every child with **empathy, patience, and openness,** regardless of the child's age, behavior, background, or circumstances.

Caseworker attitudes also shape power dynamics. Children who have experienced sexual abuse have often experienced loss of control; attitudes that are controlling, rushed, or dismissive can reinforce this harm. Child-friendly attitudes help restore a sense of choice, agency, and trust.

DISCUSS:

- How do our attitudes show up in small, everyday interactions with children?
- What behaviors might children interpret as judgement or pressure, even if unintentional?
- Which situations make it hardest to maintain a child-friendly attitude, and why?
- How can supervision and peer support help us uphold child-friendly attitudes consistently?

2.3 What Does a Child-Friendly Attitude Look Like in Practice? *(25 minutes)*

ASK what does a child-friendly attitude look like in practice?

EXPLAIN In practice, a child-friendly attitude means that caseworkers:

- **Believe the child's disclosure** and never blame the child for what happened
- **Remain calm and patient**, even when children are distressed, silent, or inconsistent
- **Listen more than they speak**, allowing the child to share at their own pace
- **Respect the child's feelings, views, and boundaries**, even when they cannot be fully accommodated
- **Avoid judgement, pressure, or leading behavior**, particularly during disclosure
- **Adapt their approach** to the child's age, developmental level, disability, culture, and emotional state
- **Explain processes clearly and honestly**, using language the child can understand
- **Acknowledge fear, shame, or confusion** as normal reactions to abuse
- **Reflect on their own reactions, beliefs, and stress levels** and seek supervision when attitudes feel challenged

Child-friendly attitudes are not static; they require ongoing reflection, supervision, and collective care to sustain, particularly in high-pressure or resource-constrained contexts.

DO: Role Play: Child-friendly attitudes in practice

Purpose of the Activity

This roleplay supports caseworkers to identify how attitudes are communicated through tone, language, and behavior, and to practice giving constructive feedback on how practice can be made more child-friendly, in line with the CCS Guidelines.

Instructions

- Divide participants into small groups.
- Ask one participant to play the caseworker, one to play the child, and the rest to observe.
- Run Roleplay A first, followed by Roleplay B.
- After each roleplay, facilitate feedback using the guiding questions.
- Observers should focus on *attitudes*, not technical case management steps, some indicators are:
  - Tone of voice
  - Pace and pauses
  - Language used
  - Non-verbal cues (body language and facial expression)
  - Power dynamics
  - Respect for choice and consent/assent
  - Emotional impact on the child

Scenario (Used for Both Roleplays)

The child is Daniel, a 10-year-old boy who disclosed sexual abuse by an older neighbor. This is the first individual session Daniel is having with the caseworker. Daniel appears quiet, avoids eye contact, and answers questions with short responses.

Roleplay A

Caseworker *(calm voice, seated at eye level):*
"Hi Daniel. My name is Sam. Thank you for coming to talk with me today. Before we start, I want you to know that you don't have to talk about anything you're not ready to talk about. We can go at your pace."

(Pauses, gives Daniel time to respond)

"I also want you to know that what happened to you is not your fault. Many children feel worried or confused when they talk about these things, that's normal."

(Gentle tone)
"If at any point you need a break, or if you don't understand something I say, please tell me. Is it okay if we talk a little today about how things have been for you recently?"

Group Feedback Questions

- What attitudes did the caseworker communicate through their tone and language?
- How did the caseworker support Daniel's sense of safety and control?

- What specific words or behaviors showed respect and belief?
- How might Daniel feel during this interaction?

Roleplay B

Caseworker *(standing, clipboard in hand, firm tone):*
"Daniel, I need you to answer some questions so that I can understand what happened. It's important that you tell me everything clearly."

(Minimal pause)
"Why didn't you tell anyone sooner? And, are you sure this happened the way you said?"

(Sighs slightly)
"We don't have much time today, so try to focus and answer properly. This information is very important."

Group Feedback Questions

- What attitudes did the caseworker communicate through their tone and language?
- How did the caseworker support Daniel's sense of safety and control?
- What specific words or behaviors showed respect and belief?
- How might Daniel feel during this interaction?

Debrief questions

After roleplay B, ask participants to give specific, constructive feedback, focusing on how the caseworker could modify their approach. For example:

- Tone: How could the caseworker's tone be calmer, warmer, or more reassuring?
- Language: Which words or questions should be changed to avoid blame, pressure, or judgement?
- Pace: Where could the caseworker slow down or pause to allow more silence?
- Non-verbal behavior: How could body position, eye level, or facial expression be more child-friendly?
- Choice and control: How could the caseworker better respect the child's right to decide what to share and when?

2.4 Coordination Implications *(10 minutes)*

EXPLAIN Child-friendly attitudes do not only affect direct interactions with children; they have significant implications for case management coordination, including referrals, information sharing, case consultations, and case conferences. The CCS Guidelines emphasize that coordination must always uphold safety, best interests, confidentiality, and meaningful participation, all of which are directly influenced by caseworker attitudes.

When caseworkers demonstrate child-friendly attitudes, coordination is more likely to be ethical, effective, and safe. When child-friendly attitudes are lacking, coordination can unintentionally increase risk and cause harm, even when procedures are followed.

DISCUSS:

- How do our attitudes influence whether children agree to referrals or coordination processes (e.g. participating in a case conference or agreeing for specific information to be shared at a case conference)?
- What risks arise when children or caregivers do not feel heard or respected in relation to case coordination processes?
- Can you think of any recent challenging coordination situations which were exacerbated by unfriendly attitudes towards child survivors indicated by service providers? What learning insights did you take away from this situation? What could have helped in this situation?
- Can you think of any specific examples from your recent caseload where coordination worked well because trust had been built?

For reference to the supervisor facilitating the session:

Positive coordination implications include:	Risks and negative coordination implications include:
• **More accurate information sharing:** Children who feel safe and respected are more likely to share relevant information, supporting appropriate referrals and coordinated responses. • **Stronger informed consent and assent:** Caseworkers who communicate respectfully and patiently are better able to explain coordination processes, enabling children and non-offending caregivers to understand, consent to, or assent to referrals and case discussions. • **Safer referrals:** Child-friendly attitudes support careful consideration of risks, ensuring referrals do not expose children to further harm, stigma, or retaliation. • **Trust-based inter-agency coordination:** Caseworkers who uphold respectful, survivor-centered practice are better positioned to advocate for the child's needs with other actors	• **Reduced disclosure and incomplete information:** Children may withhold information if they feel blamed, rushed or unsafe, leading to inappropriate or ineffective referrals. • **Weak or invalid consent processes:** If caseworker attitudes are controlling or dismissive, consent may be rushed, unclear, or not truly informed, undermining ethical coordination. • **Breach of confidentiality:** Poor attitudes may lead to unnecessary information sharing or disclosure without adequate explanation or safeguards. • **Harmful referrals:** Referrals made without careful, child-centered consideration may expose children to stigma, re-traumatization, retaliation or other protection risks. • **Erosion of trust in services:** Children and caregivers may disengage from services altogether, reducing continuity of care and increasing protection risks.

while maintaining CCS guiding principles.	• **Breakdown in coordination:** Tensions may arise between agencies if CCS principles are not upheld, particularly where children's wishes are dismissed.

2.5 Debrief *(5 minutes)*

- **ASK** participants if there are any reflections about child-friendly attitudes that they would like to share with the group before closing
- Close the session by summarizing key reflections, reinforcing links to a child-friendly attitude in case management
- **EXPLAIN:**
- Child-friendly attitudes are communicated as much through how we speak and behave as through what we say.
    - Even well-intended questions can cause harm if tone, language, or body language feels blaming or rushed.
- Supervision and group coaching spaces, like this one, can help caseworkers notice and adjust attitudes before they negatively affect children.
- **ASK** each participant to share one reflection from the session that has stood out most to them/ that they will carry with them

2.6 Session wrap-up *(5 minutes)*

- **ASK** participants to complete the session insights/ evaluation form
- **EXPLAIN** the activity caseworkers will need to complete ahead of the next session: CCS Communication Skills Assessment.
    - The CCS Communication Skills Assessment is a tool which allows supervisors to determine if a gender-based violence caseworker or a child protection caseworker has the communication skills required to work with child survivors. The supervisor will collect these and review the results with the caseworkers on an individual basis.
- **CONFIRM** date and time of session 3

SESSION 3: COMMUNICATION SKILLS

<table>
<tr><td>Session objectives</td><td>To give participants a clear understanding of the importance and necessity of positive communication skills when working with child survivors
To provide an opportunity for reflexive practice applying positive communication skills with child survivors, including delivery of healing statements.</td></tr>
<tr><td>Session Duration:</td><td>60 minutes</td></tr>
<tr><td>Session content overview and recommended timings</td><td>Welcome (5 mins)
Self-care exercise
Re-cap of child-friendly communication skills and communication skills assessment (10 mins)
Verbal/ non-verbal and active listening
Use of healing statements
What do child-friendly communication skills look like in practice? [35 mins)
Successes and struggles within case management
Practice / case-studies in pairs
Debrief (5 mins)
Session wrap-up (5 mins)</td></tr>
<tr><td>Session materials</td><td>Handouts
Case study scenarios
Session insights/evaluation form</td></tr>
<tr><td>Pre-session reflection / activity for caseworkers</td><td>CCS Communication Skills Assessment for supervisees to complete and send to their supervisor well ahead of the session for their review.
Supervisors should review the assessments from their supervisees ahead of session and review common themes / issues to discuss and address.</td></tr>
<tr><td>Optional Post-Session Reading</td><td>Chapter 4 of the CCS Guidelines (pages 71 – 91)
Module 4 of CCS training package
Module 4 Handout – Communication Do’s and Don’ts</td></tr>
</table>

Session 3 content

3.1 Welcome *(5 minutes)*

- Welcome the participants to the coaching session
- **SAY** coaching sessions are safe learning sessions where questions and inputs are welcome to support growth and learning
- **ASK** how participants have felt since the last session, if there are any questions or reflections from the previous session that they would like to ask/share
- **EXPLAIN** that today's session will focus on child-friendly communication skills, and confirm everyone understands what is meant by this
- The goal of communication between a caseworker and a child survivor is to establish a trusting, safe, and supportive helping relationship. Every meeting with the child survivor and non-offending caregiver is an opportunity for the caseworker to strengthen the helping relationship.
- **EXPLAIN** that the pre-session activity was the CCS Communication Skills Assessment, a tool which allows supervisors to determine if a gender-based violence caseworker or a child protection caseworker has the communication skills required to work with child survivors. The supervisor will collect these, and review the results with the caseworkers on an individual basis.

DO: Self-care exercise: Body scan

Sitting comfortably, ask participants to take a deep breath in through the nose, and out through the mouth. As they exhale, suggest they gently close the eyes.

Explain to participants that we will start at the top of the head and gradually scan down through the body. Ask them to notice how each part feels; relaxed or tense? light or heavy? comfortable or uncomfortable? The exercise is not trying to change anything, just pausing and becoming aware of the state of our bodies. Breath by breath, continue down the body noticing how it feels through the shoulders, arms, chest, stomach, hips, legs, and finally, the feet.

Let each breath support attention. If the mind wanders, gently bring it back to wherever it left off.

3.2 Re-cap of child-friendly communication skills & communication assessment *(10 minutes)*

- **SAY:** The CCS Guidelines emphasize that how caseworkers communicate with child survivors is as important as what they do. Positive, child-friendly communication skills are essential to creating safety, building trust, supporting disclosure, and reducing the risk of re-traumatization. Children who have experienced sexual abuse may feel fear, shame, confusion, or loss of control; insensitive, rushed, or poorly attuned communication can unintentionally reinforce harm and discourage engagement.

Effective communication supports the CCS guiding principles by enabling informed consent and assent, meaningful participation, and survivor-centered decision-making. Positive communication skills help children feel believed, respected, and supported throughout the case management process.

Verbal Communication

This includes the words, questions, and explanations used with children.

ASK participants for some examples of verbal communication before sharing the following if they have not already been identified:

- Use clear, simple, age-appropriate language
- Avoid leading, suggestive, or "why" questions that may feel blaming
- Provide honest information about processes and limits to confidentiality
- Pace questions slowly and allow time for responses

Non-Verbal Communication

Non-verbal behavior often communicates attitudes more strongly than words.
ASK participants for some examples of non-verbal communication before discussing the following:

- Sitting at the child's eye level
- Maintaining a calm, open posture
- Using gentle facial expressions and using appropriate facial expressions to match the discussion and what the child / non-offending caregiver is sharing
- Respecting physical space and boundaries
- Avoiding signs of impatience (e.g. rushing, sighing, excessive notetaking)

Active Listening

Active listening shows the child they are heard and valued.
ASK participants for some examples of active listening before discussing the following:

- Giving full attention without interruption
- Using affirming responses (e.g. nodding, short acknowledgements)
- Reflecting back feelings or key points
- Allowing silence without pressure

Use of Healing Statements

Healing statements are a core CCS communication skill that help counter self-blame, fear, and shame. When used appropriately, they support emotional safety and validation.
ASK participants for some examples of healing statements before discussing the following:

- "What happened to you was not your fault."
- "You did the right thing by telling someone."
- "Many children feel confused or scared after something like this."

- "You are not alone, and support is available."

Healing statements should be:

- Genuine and calm
- Used at appropriate moments, not repeatedly or mechanically
- Matched to the child's emotional state and understanding

3.3 What do child-friendly communication skills look like in practice? *(35 minutes)*

ASK: What do child-friendly communication skills look like in practice?

DO: Supervisors should facilitate a discussion of the child-friendly communication skills, using the group discussion table to prompt reflection and engagement. This activity may be completed prior to the case study, or if the group has a strong grasp of child friendly communication skills, can move directly to the case study activity

DISCUSS child-friendly communication skills at each step of case management, andwhat examples of successes and struggles with communication can look like. The table can be used to prompt discussion and demonstrate the significance of communication skills at each step.

	Communication focus	Successes	Struggles
Step 1: Introduction and Engagement	: Building safety, trust, and rapport.	• Caseworker uses a calm tone, simple language, and open body posture • Introduces themselves clearly and explains their role • Allows the child to set the pace and respects silence • Uses healing statements to reduce fear and self-blame	• Rushing the introduction due to time pressure • Using formal or technical language • Standing over the child, limited eye contact, or distracted notetaking • Asking questions before trust is established
Step 2: Assessment	Gathering information without causing harm.	• Uses open, non-leading questions • Actively listens and reflects back feelings • Adapts communication to the child's age, development, and emotional state • Balances information gathering with emotional support	• Asking too many questions at once • Interrupting or correcting the child • Displaying shock, disbelief, or impatience through non-verbal cues • Over-focusing on forms rather than the child
Step 3: Case Action Planning	Participation, understanding, and choice.	• Explains options clearly and checks understanding • Involves the child (and non-offending caregiver) in decisions, where appropriate	• Making decisions without involving the child • Explaining plans in adult-centered or technical language • Assuming consent without confirming understanding

		• Uses simple explanations of next steps • Reinforces the child's right to have a say	• Minimizing the child's concerns or preferences
Step 4: Implementation	Ongoing support and reassurance.	• Provides regular updates in child-friendly language • Uses healing statements during stressful moments • Checks in emotionally, not only on tasks • Prepares the child for what to expect	• Communication becomes task-driven • Child is not prepared for referrals or coordination activities • Infrequent or unclear communication increases anxiety • Caseworker avoids difficult conversations
Step 5: Case Follow-Up	Reflection, adjustment, and continuity.	• Asks the child how they are feeling about the support received • Adjusts communication based on feedback • Validates ongoing emotions or setbacks • Maintains a respectful, consistent tone	• Assuming improvement without checking • Reducing contact without explanation • Focusing only on progress indicators, not emotional wellbeing • Missing signs of distress or disengagement
Step 6: Case Closure and Evaluation	Preparation, clarity, and respectful endings.	• Prepares the child in advance for closure • Explains why the case is closing and what support remains • Acknowledges the child's efforts and strengths • Allows space for questions and feelings	• Abrupt or poorly explained closure • Using adult-centered language • Avoiding emotional goodbyes • Child feels abandoned or confused

DISCUSS:

- At which step of case management do communication challenges most often arise?
- How do stress, workload, or time pressure affect our communication?
- Which communication skills do we use confidently, and which need strengthening?
- How can supervision and peer support help maintain positive communication under pressure?

Supervisor note: Supervisors should add further observations and comments based on the specifics from the pre-session communication assessments they reviewed from their supervisees.

DO: Case study: Applying Child-Friendly Communication Skills in Practice

Purpose of the Activity

This activity supports caseworkers to practice identifying and applying positive, child-friendly communication skills across case management steps. It helps participants recognize how communication successes and struggles commonly arise at different stages of case management and strengthens their ability to adapt verbal communication, non-verbal behavior, active listening, and healing statements in line with the CCS Guidelines.

Instructions

- Divide participants into pairs.
- Assign each pair one case study, give them 10 minutes to discuss the scenario and discussion prompts
- Bring the group back together to debrief, inviting pairs to share one communication success, one communication struggle, and/or one practical adjustment a caseworker could make
- **Supervisor note**: for one-to-one coaching, decide whether there is enough time to review both case studies

Case Study A: Younger Child – Early Steps

Scenario

Sara is 7 years old and has been referred following sexual abuse by a neighbor. This is her first session with the caseworker. Sara avoids eye contact, clutches a toy, and answers in one-word responses.

In pairs, discuss:

- Which communication skills are most important at Step 1 (Introduction and Engagement) and Step 2 (Assessment)
- What verbal, non-verbal, and active listening skills should be prioritized
- What healing statements would be appropriate
- What could make Sara feel safer in the first minutes of contact?

- What communication mistakes could increase fear or withdrawal?
- How should the caseworker pace information gathering?

Case Study B: Adolescent – Later Steps

Scenario
Michael is 15 years old and has been working with his caseworker for several months. He has become quieter during follow-up sessions and says he "doesn't care anymore." A referral for specialized MHPSS support is being considered, and case closure may follow in the coming weeks.

In pairs, discuss:

- Communication successes and risks at Step 4 (Implementation), Step 5 (Follow-Up), and Step 6 (Closure)
- How to explain referrals and case closure in a child-friendly way
- How to use healing statements without sounding dismissive or repetitive
- How might tone and body language affect Michael's engagement?
- What should be explained clearly before referrals or closure?
- How can the caseworker acknowledge Michael's feelings without pressure?

3.4 Debrief *(5 minutes)*

- **ASK** participants if there are any reflections about child-friendly communication skills that they would like to share with the group before closing
- Close the session by summarizing key reflections, reinforcing links to the CCS Guidelines overview of communication skills
- **EXPLAIN**:
  - Emphasize that communication skills must be adapted at each step, not used in the same way throughout
  - Reinforce that struggles are common and supervision is a space to strengthen practice
  - Link reflections back to child safety, participation, and do-no-harm principles
- **ASK** each participant to share one reflection from the session that has stood out most to them/ that they will carry with them

3.5 Session wrap-up *(5 minutes)*

- **ASK** participants to complete the session insights/ evaluation form
- **CONFIRM** date and time of session 4

SESSION 4: INCLUSIVE COMMUNICATION TECHNIQUES

Session objectives	• To give participants a clear understanding of the importance and necessity of using effective (age and developmentally applicable) communication techniques when working with child survivors • To provide an opportunity for reflexive practice on applying effective communication techniques with child survivors.
Session Duration:	60 minutes

Session content overview and recommended timings	• Welcome *(5 mins)*
	• What are inclusive communication techniques? *(10 mins)*
	  ○ Directive / non-directive techniques
	  ○ Approaches according to age and capacity
	• Specific considerations for communicating with children with disabilities *(5 mins)*
	• Key challenges discussion *(20 mins)*
	  ○ Inclusive communication techniques practice
	• Coordination implications *(10 mins)*
	• Debrief *(5 mins)*
	• Session wrap-up *(5 mins)*

Session materials	Handouts • Roleplay exercise • Session insights/evaluation form
Pre-session reflection / activity for caseworkers	• N/A
Optional Post-Session Reading	• Chapter 4 of the CCS Guidelines (pages 71 – 91) • Module 4 of CCS training package • Module 4 Handout – Communication Do's and Don'ts

Session 4 content

4.1 Welcome *(5 minutes)*

- Welcome the participants to the coaching session
- **SAY** coaching sessions are safe learning sessions where questions and inputs are welcome to support growth and learning
- **ASK** how participants have felt since the last session, if there are any questions or reflections from the previous session that they would like to ask/share
- **EXPLAIN** that today's session will continue focusing on child-friendly communication skills, specifically inclusive communication techniques

DO: Self-care exercise: Grounding and Reset

Invite participants to sit comfortably. Let them know this is a brief pause and that participation is voluntary. Ask participants to:

- Place both feet on the floor
- Take a slow breath in through the nose
- Gently exhale through the mouth
- Repeat this 3–4 times, at their own pace

Invite participants to silently notice:

- One place in their body that feels tense
- One place that feels relaxed or neutral
  Encourage them to soften the tense area slightly with the next exhale.

Ask participants to silently name:

- One thing they are carrying from their work today
- One small thing that helps them feel steadier or supported

Thank participants and gently transition back to the session.

4.2 What Are Inclusive Communication Techniques? *(10 minutes)*

ASK What are inclusive communication techniques?

EXPLAIN: Inclusive communication techniques are approaches that ensure all children, regardless of age, developmental stage, disability, language, or emotional state, can understand, participate in, and feel safe during case management interactions. The CCS Guidelines emphasize that inclusive communication is essential to upholding the principles of safety, non-discrimination, meaningful participation, and do-no-harm.

Inclusive communication requires flexibility: caseworkers must adapt *how* they communicate to each child's capacity, needs, and context, rather than expecting children to adapt to adult systems or communication styles.

Non-Directive Communication Techniques

Non-directive communication allows the child to lead the pace and content of the interaction, supporting autonomy and emotional safety; these can be verbal and non-verbal.

ASK participants for some examples of non-directive communication before discussing the following:

- Open-ended prompts (e.g., "Would you like to tell me what today has been like for you?")
- Reflecting feelings or words back to the child
- Allowing silence and pauses
- Following the child's cues about what they are ready to share
- Non-verbal communication technique: inviting the child to draw a picture or tell a story, with no specific directions about what

When it is most appropriate:

- During engagement and trust-building
- When supporting disclosure
- When a child is distressed, withdrawn, or unsure

Directive Communication Techniques

Directive communication involves providing clear structure, guidance, or information to support understanding and safety.

ASK participants for some examples of directive communication before discussing the following:

- Explaining processes step by step
- Giving clear choices (e.g., "You can choose to talk now or take a break")
- Asking focused, necessary questions
- Clarifying limits to confidentiality or safety actions
- Non-verbal communication technique: ask child to draw their family/ daily activities, or ask child to use dolls/ puppets to answer questions

When it is most appropriate:

- When explaining consent, assent, or next steps
- During safety planning or referrals
- When a child needs clarity to reduce anxiety

Adjustments for age/ developmental stage and disability

0-5 years old	• Limited verbal communication skills - unable to directly disclose • Should not be communicated with directly about their sexual abuse • Non-offending caregiver(s) are the primary source of information about the child survivor and sexual abuse
6-12 years old	• 30 minutes or less • Can be directly communicated with about sexual abuse • The non-offending caregiver(s) or someone child survivor trusts can accompany them • Use toys, art, and other child-friendly materials • Gather details from trusted sources in the child survivor's life with informed assent/consent
13-18 years old	• 30-60 minutes • Communicate directly with child survivors in this age range • Non-offending caregiver(s) or someone the child survivor trusts can be involved if requested by the child survivor • Use of art and other adolescent-friendly materials may assist communication and be helpful for enabling the adolescent's self-expression
Children with disabilities	• Do not assume all children with disabilities cannot communicate or communicate differently from other children • Communication capacity depends on the type of disability • Non-offending caregivers or other trusted persons can advise on how to communicate with the child survivor

4.3 Specific Considerations for Communicating with Children with Disabilities *(5 minutes)*

EXPLAIN: The CCS Guidelines stress that children with disabilities face increased risks of exclusion and harm if communication is not adapted appropriately.

ASK: What considerations should be taken when communicating with children who have disabilities? before discussing the following examples:

- Ask the child (and non-offending caregiver, where appropriate) how they prefer to communicate
- Use visual aids, gestures, or assistive communication tools if needed
- Speak directly to the child, not only to caregivers or interpreters

- Avoid assumptions about cognitive or emotional capacity
- Allow extra time and repeat information as needed
- Ensure the environment supports communication (quiet space, seating, lighting)

Inclusive communication with children with disabilities is essential to ensuring equitable access to services and meaningful participation.

4.4 Key Challenges in Inclusive Communication *(20 minutes)*

Supervisors should normalize for caseworkers that inclusive communication is challenging and takes conscious and intentional effort.

ASK participants what are some challenges they have experienced using inclusive communication techniques?

Some common challenges could include:

- Time pressure leading to rushed communication
- Balancing directive and non-directive approaches
- Limited experience communicating with children with disabilities
- Language barriers or lack of interpreters
- Caseworker discomfort or fear of "saying the wrong thing"
- Emotional distress (child or caseworker) affecting communication

Group coaching and supervision are critical spaces to reflect on these challenges and strengthen practice.

DO: Role play: Applying Inclusive Communication Techniques in Practice

Purpose of the Activity

This roleplay supports caseworkers to practice adapting inclusive communication techniques, including directive and non-directive approaches (according to a child's age, capacity, and whether they have a disability) in line with the CCS Guidelines. The activity helps participants recognize how communication choices affect safety, participation, and understanding.

Instructions

- Divide participants into small groups, assign 1 caseworker, 1 child, and 1-3 observers
- Ask observers to focus on:
- Use of directive vs non-directive communication
- Adaptation to child's age and capacity
- Verbal, non-verbal, and pacing choices
- Each roleplay should last 5–7 minutes, followed by feedback. Groups may rotate roles if time allows

Roleplay Scenario 1: Younger Child with Limited Verbal Expression

Scenario

The child is Leila, aged 6. She communicates mostly through drawing and gestures and becomes quiet when asked direct questions. This is an early engagement session.

Guidance for the Child Role

- Avoid eye contact initially
- Respond with gestures or drawings rather than words
- Become quieter if the caseworker asks many direct questions

Guidance for the Caseworker Role

- Use non-directive communication to support engagement
- Introduce directive communication only when needed (e.g. explaining purpose or offering choices)
- Adapt language, pace, and non-verbal cues

Observer Feedback Questions

- Which non-directive techniques helped Leila feel safer?
- When was directive communication useful or necessary?
- How did tone, body position, and pacing affect participation?
- What could be adjusted to be more inclusive?

Roleplay Scenario 2: Adolescent with a Disability

Scenario

The child is Omar, aged 14, with a physical disability and mild learning difficulties. This is a case action planning discussion. Omar agrees quickly but does not ask questions.

Guidance for the Child Role

- Nod and agree without asking for clarification
- Give short responses
- Appear unsure but polite

Guidance for the Caseworker Role

- Balance directive communication (explaining options and next steps) with non-directive communication (checking understanding and inviting views)
- Consider relevant inclusive communication techniques

Observer Feedback Questions

- How did the caseworker check understanding and consent/ assent?
- Were assumptions made about Omar's capacity?
- How could communication better support meaningful participation?
- What adaptations could strengthen inclusion?

4.5 Coordination Implications *(10 minutes)*

EXPLAIN: Inclusive communication techniques directly affect how well case management coordination functions in practice. The CCS Guidelines emphasize that coordination (such as referrals, information sharing, case consultations, and case conferences) must uphold safety, informed consent/assent, meaningful participation, and do-no-harm. These elements depend on whether communication is inclusive, accessible, and adapted to each child's age, capacity, and needs.

DISCUSS:

- How does inclusive communication affect a child's willingness to agree to referrals or coordination?
- Where do coordination challenges arise when communication is rushed or adult-centered?
- How can we adapt communication to ensure children with disabilities are not excluded from coordination processes?
- What role does supervision play in strengthening inclusive communication during coordination?

For reference to the supervisor facilitating the session:

Positive coordination implications include:	**Risks and negative coordination implications include:**
• **Informed and valid consent/assent for coordination:** Children and non-offending caregivers are more likely to understand why coordination is needed, what information will be shared, and with whom, enabling genuine consent or assent rather than passive agreement. • **Safer and more appropriate referrals**: Inclusive communication allows caseworkers to identify the child's actual needs, preferences, and fears, leading to referrals that are relevant, timely, and less likely to cause harm or disengagement. • **Meaningful participation in case action planning:** When communication is adapted to age and capacity, children's views can be represented accurately, supporting	• **Invalid or misunderstood consent/assent:** Children may agree to coordination activities without understanding them, leading to ethical concerns and potential harm. • **Inappropriate or harmful referrals:** Referrals may be made based on incomplete understanding of the child's needs, resulting in services that are inaccessible, distressing, or unsafe, particularly for children with disabilities. • **Exclusion from decision-making:** Children may be effectively excluded from coordination processes because communication is too complex, rushed, or adult-centered. • **Misrepresentation of the child's views:** Poor communication can result in inaccurate representation of

decision-making that reflects their best interests. • **Improved information quality and coordination outcomes:** Children who feel understood and respected are more likely to share accurate and relevant information, improving coordination across sectors (e.g. CP, GBV, MHPSS, health, legal). • **Stronger trust in coordinated services:** Inclusive communication builds confidence in services, increasing follow-through on referrals and continuity of care.	the child's wishes during case consultations or conferences. • **Breakdown in inter-agency coordination:** When children disengage due to poor communication, follow-up across services weakens, increasing protection risks. • **Increased risk of re-traumatization or stigma:** Coordination activities conducted without inclusive communication may expose children to repeated questioning, confusion, or harmful interactions.

4.6 Debrief *(5 minutes)*

- **ASK** participants if there are any reflections about inclusive communication techniques that they would like to share with the group before closing
- Close the session by summarizing key reflections, reinforcing links to the CCS Guidelines overview of communication skills,.
- **EXPLAIN**:
    - Inclusive communication requires intentional adaptation, not fixed scripts
    - Both directive and non-directive techniques are necessary
    - Children with disabilities require communication adjustments, not reduced participation
    - Roleplay and reflection help identify habits that may unintentionally exclude children
- **ASK** each participant to share one reflection from the session that has stood out most to them/ that they will carry with them

4.7 Session wrap-up *(5 minutes)*

- **ASK** participants to complete the session insights/ evaluation form
- **CONFIRM** date and time of session 5

SESSION 5: COMPLEXITIES RELATING TO CASE MANAGEMENT STEPS AND PROCESS

Session objectives	• To re-cap some of the key issues / complexities that may arise in CCS case management • To provide an opportunity for reflexive practice on navigating two selected complexities within the context.
Session Duration	60 minutes
Session content overview and recommended timings	• Welcome *(5 mins)* o Self-care exercise • Key issues and complexities relating to case management process overview (Group select two from list for deeper reflection) *(40 mins)*: o Working with adolescent girls o Working with children with disabilities o Best interests of the child o Mandatory reporting (if applicable) o Information management / information sharing o Caregivers who are perpetrators o Child sexual abuse cases where the abuser is another child • Debrief *(10 mins)* • Session wrap-up *(5 mins)*
Session materials	Handouts • Session insights/evaluation form
Pre-session reflection / activity for caseworkers	• Ask participants to complete the ranking worksheet one week ahead of time, in order to determine the focus topics for session 5 & session 6
Optional Post-Session Reading	• Chapter 5 of the CCS Guidelines (pages 92-110) • Module 5 of the CCS training package • UNHCR Best Interests Procedure for Refugee and Asylum-seeking Children at Risk (online course): • UNHCR (2021) Best Interests Procedure Guidelines: Assessing and Determining the Best Interests of the Child

Session 5 content

5.1 Welcome (5 minutes)

- Welcome the participants to the coaching session
- **SAY** coaching sessions are safe learning sessions where questions and inputs are welcome to support growth and learning
- **ASK** how participants have felt since the last session, if there are any questions or reflections from the previous session that they would like to ask/share
- **EXPLAIN** that today's session will focus on key issues and complexities relating to the case management process. Specifically, we will cover [insert 2 topics] based on the ranking exercise completed ahead of time. The next session will cover two more topics.

DO Self-care exercise: One Minute Gratitude Prompt

Ask participants to think of:

- One thing that went well today
- One person they appreciate
- One thing they're looking forward to

Invite participants to share if they would like. There is no expectation, just time for a mental shift as we begin the session.

5.2 Key issues and complexities relating to case management process *(40 minutes total – 20 minutes per topic)*

EXPLAIN this session provides an opportunity for caseworkers to reflect on complex and sensitive issues that can arise during CCS case management. Case management is a systematic process in which a trained and supervised caseworker assesses the needs of a client and, when appropriate, the client's family. They then arrange, and sometimes provide, coordinate, monitor, evaluate and advocate for a package of multiple services to meet the specific client's complex needs.

When issues arise, caseworkers need to consider balancing:

- Child safety
- Child participation
- Family dynamics
- Legal and policy requirements
- Available services

Supervision is essential when cases involve heightened risk or ethical tension.

Topic	Working with Adolescent Girls
Why this can be complex	**Adolescent girls who experience sexual abuse often face:** • Pressure to marry, reconcile, or remain silent • Blurred expectations around adulthood and responsibility • Increased risk of IPV, stigma, or exclusion, withdrawal from education and other opportunities • Limited safe choices despite appearing "independent" Their participation must be supported **without making them feel responsible for protecting themselves.**
Some pitfalls in these cases include…	• Treating adolescent girls as adults • Survivor-blaming– lack of child-friendly attitudes • Underestimating risk if the adolescent girl appears confident • Focusing predominantly on health risks (e.g. unintended pregnancy), not sufficiently considering additional needs
Caseworkers should be sure to…	• Recognize adolescent girls as children with evolving capacities • Balance participation with protection and safety • Reflect on power, gender norms, and community pressure
Exercise	**Short Vignette** [NAME] is a 16-year-old girl who disclosed sexual abuse by an older man. Community leaders are pressuring her family to agree to a marriage to "resolve the situation." She says she feels angry but also worried about causing problems for her parents. She appears calm during sessions but avoids discussing the future. **Discussion prompts:** • What additional risks are present in this situation? • How do we support her participation in the case management process without placing responsibility on her? • What supervision and coordination support is needed?
Plenary debrief	• How do we ensure adolescent girls' voices are heard without exposing them to additional risk?

Topic	Working with Children with Disabilities
Why this can be complex	**Children with disabilities:** • Children with disabilities face significantly higher risk for sexual abuse compared to children without disabilities of the same age and gender. • Depending on the type of disability a child has, they may be less able to express themselves and disclose to others the abuse they are experiencing, more susceptible to grooming tactics (for example, if a child has certain mental disabilities). • Adolescent girls with disabilities may be less able to advocate for their sexual and reproductive health needs and wishes because of biases and stereotypes (for example, that they are unable to understand, do not have sexual desires, and do not know what is best for them, etc.). • Children with disabilities may also face drastically different responses to their abuse, including being less likely to be believed when they disclose experience(s) of sexual abuse because of beliefs about their intellectual capacity, even if their disability doesn't affect intelligence. • Further, adaptations and accessibility needs vary depending on a child's disability.
Some pitfalls in these cases include…	• Speaking only to caregivers • Failure to recognize that caregivers / guardians may be perpetrators • Confusing communication difficulty with lack of understanding • Excluding the child from decisions "for their protection" • Recommending inaccessible services
Caseworkers should be sure to…	• Avoid assumptions about understanding or credibility. **Accessibility to services** must be considered from both physical standpoints (ramps, safe location, positioned away from areas of concern like bars, cinemas, cafes, police or security stations, etc.) and communication and attitude standpoints (caseworkers have examined their attitudes and beliefs about people with disabilities, understand how to adapt communication, etc.) • Communicate directly with the child wherever possible, including providing **reasonable accommodation** to ensure a child's participation. o This may include readily available sign language interpreters, easy-to-read forms, a personal assistant for

	the child, allowing more time and space to explain concepts and options and for the child's questions and concerns about them.
	• Examine personal attitudes about disabilities
	• Understand that disabilities result primarily from societal barriers rather than from the impairment of the child;
	• Consider and recognize the barriers to inclusion for children with disabilities, and promote accessibility and inclusion:
	    ○ assess own services and use reasonable accommodation to remove communication and physical barriers;
	    ○ assess referral services for safety and attitudes regarding children with disabilities;
	    ○ be aware of the ways a child's condition may impact their sexual and reproductive health needs (for example, some conditions may cause puberty to begin earlier while others delay it)

Exercise	**Short Vignette** [NAME] is an 8-year-old child with a hearing impairment. Her parents are supportive, but service providers often speak only to them. She appears attentive and curious but rarely participates directly in discussions. Her parents report she becomes anxious before appointments. **Discussion prompts:** • How can communication be adapted to include her directly? • What assumptions should be challenged? • How can supervision support inclusive practice?
Plenary debrief	• How do you treat people with disabilities? • What were you taught about people with disabilities as a child? • How do you treat people with disabilities now? • How can you work with a child with a disability in a way which centers their agency and respects their needs?

Topic	Best Interests of the Child
Definition	In case management of child survivors, actions that promote children's best interests are those that: • protect the child from potential or further emotional, psychological and/or physical harm; • reflect the child's wants and needs; • empower children and families; • examine and balance benefits and potentially harmful consequences; promote recovery and healing
Why this can be complex	**Best interest determinations / decisions:** • Are not always clear or agreed upon • May conflict with caregiver or community views • Must balance safety, wellbeing, and the child's views • Can change over time
Some pitfalls in these cases include…	• Defaulting to adult or institutional priorities • Treating best interests as fixed • Avoiding decisions due to fear of being wrong
Caseworkers should be sure to…	Determine which courses of action are in the best interests of a particular child. This requires the caseworker to: • carry out a careful evaluation of the child's situation; • hold meaningful discussions with the child and caregivers about what they believe is in the child's best interests; and • seek the least harmful course of action Throughout the case management process caseworkers will encounter issues that require careful analysis and thoughtful decision-making in order to fulfil their roles and more to uphold the best interests of the child based on their unique characteristics, set of circumstances and available support.
Exercise	**Short Vignette** [NAME] is a 10-year-old boy who wants to continue living with his family despite concerns about supervision and safety. His caregiver insists the situation is "under control." The child says he feels safe but appears anxious during sessions. **Discussion prompts:**

	• How do we weigh the child's views alongside safety concerns? • What information is missing? • How does supervision support best-interest decisions?
Plenary debrief	• What tensions do you see between upholding the best interests of a child and respecting their needs and perspectives? • What opportunity do you see for strengthening application of the best interest principle in your current caseload? • When do you think you may need further guidance or support from your supervisor to support best interest decisions?

Topic	Mandatory Reporting
Definition	Mandatory reporting laws typically require public service providers, such as doctors, nurses, police, social workers and teachers, who regularly work with children to report suspected or known cases of child maltreatment to specific agencies. Depending on the context, reports may be made directly to the police, to government child protection agencies, or to specific departments within justice systems. Where mandatory reporting laws exist in relation to child abuse, the ultimate objective is to protect children from harm and ensure action is taken by proper authorities when abuse is known or suspected. In GBV work, mandatory reporting is almost always considered harmful because it usually involves going against the expressed wishes of an adult survivor or compelling an adult survivor to report to authorities to access a needed service which most often has safety implications. With children, this is not always the case. There are some scenarios when mandatory reporting may be beneficial and of added benefit for the child and their non-offending caregivers. For example, in a setting with well-established social services and justice mechanisms, mandatory reporting could result in much-needed additional support for a child survivor of sexual abuse and their non-offending caregivers.
Why this can be complex	**Mandatory reporting:** • Can strain trust with children and caregivers • Can strain trust between children and caseworkers / service providers in general • May increase risk if poorly explained or timed • Can create ethical tension for caseworkers
Some pitfalls in these cases include…	• Delaying explanation • Complexity – in some settings mandatory reporting procedures are not clear or evolve over time. • Making promises that cannot be kept • Treating reporting as purely procedural

Caseworkers should be sure to…	In order to safely and effectively implement mandatory reporting requirements, caseworkers must have an accurate understanding of the mandatory reporting laws/policies in their context; Specifically: • whether the mandatory reporting laws apply to caseworkers, health staff, other service providers (for example, in some contexts, mandatory reporting laws may require health staff to report but not caseworkers); • how these laws/policies impact the child and their non-offending caregivers; • how to explain laws/policies to the child and their non-offending caregivers; • potential risks to mandatory reporting for all child survivors (for example, police ill-trained/ not trained on child sexual abuse, punitive actions for child and/or non-offending caregiver, broken or fractured legal system with little likelihood of justice, etc.); • potential risks to mandatory reporting for child survivors that may be identity specific (for example, discriminatory practices against refugee children, sexual stereotyping that results in re-victimization for particular adolescent girls by police or others in justice system, specific harmful practices like honor killing or child, early or forced marriage); • understand who they (the caseworker) should go to if the risks outweigh potential benefits to mandatory reporting. • analyze specific criteria to determine whether reporting is in the child's best interests, and document and report this information to supervisors; • explain mandatory reporting requirements to children and caregivers at the outset of service delivery. This should happen as part of the informed consent process in Step 1 Introduction and Engagement • it is important that caseworkers inform the child and caregiver prior to making a referral and discuss possible consequences of a mandatory report and make a safety plan related to it. • monitor for changes in mandatory reporting procedures as part of their continuous professional development / capacity strengthening, with support from their supervisors. If a mandatory report is required, caseworkers must share the following information at the start of the first meeting with a child survivor and non-offending caregiver: • the agency/person to which/whom the caseworker will report; • the specific information being reported;

	• when and how the information must be reported (written, verbal, etc.); • the likely outcome of the report; • the child's and family's rights in the process. Children, particularly older children (adolescents), and caregivers should be part of the decision-making process on how to address mandatory reporting in the safest and most confidential way. This means caseworkers should seek and consider their opinions and ideas on how to make the report. This does not mean the caregiver and child can decide whether a report is made; rather, they can help decide how and when the report is made. The best interests of the child should always be the primary consideration when taking actions on behalf of children, even in the context of mandatory reporting laws. The most beneficial/least detrimental course of action for the child, and the least intrusive one for the family, should be employed as long as the child's safety is assured.
Exercise	**Short Vignette** [NAME] is a 13-year-old who discloses sexual abuse during a session and asks the caseworker not to tell anyone. Mandatory reporting laws apply. The child becomes quiet when reporting is mentioned. **Discussion prompts:** • How can reporting be explained in a child-friendly way? • What support does the caseworker need? • How can trust be maintained?
Plenary debrief	• What tensions do you see between mandatory reporting and respecting the child survivors' confidentiality, needs and wishes? • What opportunity do you see for strengthening understanding of mandatory reporting and navigating it in your current caseload? • When do you think you may need further guidance or support from your supervisor in relation to mandatory reporting?

Topic	Information Management and Information Sharing
Definition	In line with the principles for good coordination, information sharing within the context of dealing with survivors of child sexual abuse should be based on a strict interpretation of the principles of informed consent and assent and 'need to know' and should be aligned with the Child Protection Information Management System and the GBV Information Management System. When details of a specific case should be shared exclusively with individuals (rather than organizations) who are directly involved in supporting the survivor and/or their caregiver, the information shared should be the minimum required by the receiving service provider for the specific purpose of providing a service or otherwise supporting the child and/or their caregiver. Referral mechanisms for cases of child sexual abuse should be designed with the utmost regard for the safety and confidentiality of the survivor and their caregiver. For instance, hard-copy referral forms should never include identifying information and electronic referral forms should be protected via a unique password (not shared with any other case/referral form) or other single-use encryption method. Individual-level data, even if it does not include identifying details, should never be shared with individuals, actors and/or organizations that are not directly involved in the provision of services to the survivor. The only exception to this rule occurs when mandatory reporting requirements are in place, which must be communicated to the survivor and/or their caregiver in advance
Why this can be complex	**Information sharing:** • Is essential for protection and coordination • Can increase risk if mishandled • Requires consent, clarity, and purpose
Some pitfalls in these cases include…	• Over-sharing "just in case" • Under-sharing due to fear • Assuming consent without clear explanation
Caseworkers should be sure to…	• Share information on a need-to-know basis • Explain information sharing clearly to children and caregivers and cross-checking that their comprehension • Make clear to survivors and non-offending caregivers that they can withdraw consent / assent to share information and be

	selective about which agencies they share what specific information with (whilst accounting for mandatory reporting. See mandatory reporting section above). • Document decisions and rationale • Pause and consult supervision when unsure
Exercise	**Short Vignette** [NAME] is receiving support from a caseworker due to sexual abuse perpetrated by a neighbor. Another agency requests detailed case information for a coordination meeting. The child has not been told about this request and is fearful of others knowing about the abuse. **Discussion prompts:** • What information is necessary to share? • How should consent be handled? • What supervision guidance is needed?
Plenary debrief	• What tensions do you see between information sharing and respecting the child survivors' confidentiality, needs and wishes? • What opportunity do you see for strengthening your information management and your information sharing practices within your current caseload? • When do you think you may need further guidance or support from your supervisor in relation to information management and information sharing?

Topic	Caregivers Who Are Perpetrators
Definition	A perpetrator is the person or persons who sexually abuse a child. Perpetrators of child sexual abuse may be known or unknown persons to the child. Caregivers can perpetrate sexual abuse of children and abuse and misuse their trust. Caseworkers should not work directly with caregivers who are perpetrators as this can jeopardize the safety and confidentiality of the child survivor. Perpetrators of child sexual abuse are often, although not always, men.
Why this can be complex	When caregivers are perpetrators: • Child safety may conflict with family preservation • Engagement carries risk to survivors • Engagement carries risk to caseworkers, service providers and in some contexts to their extended family and social networks • Caregiver perpetrators may deny they are responsible for the abuse and claim that others are responsible for the abuse. They may attend appointments with child survivors to control the narrative and the type / range of services a child survivor has access to. • Children may feel loyalty, fear, or dependence towards the perpetrator
Some pitfalls in these cases include…	• Failure to identify the caregiver as the perpetrator • Working with / engagement with perpetrators giving them access to information and control in decision-making which they should not have if they are abusing children in their care and unable to act in the best interest of the child • Minimizing risk to preserve relationships • Managing these cases without supervision
Caseworkers should be sure to…	• Prioritize child safety and best interests • Maintain clear professional boundaries • Avoid working directly with perpetrators and being alert to the fact that some caregivers are perpetrators • Avoid negotiating safety directly with perpetrators • Use supervision and coordination consistently • Flag and report concerns relating to their personal wellbeing and safety to their supervisors

<table>
<tr><td>Exercise</td><td>Short Vignette A

[NAME] is a 9-year-old whose stepfather is the alleged perpetrator. The child's mother is conflicted and asks the caseworker not to involve other services. The child appears withdrawn and anxious during sessions.
Discussion prompts:
What are the immediate safety concerns?
How should caregiver engagement be handled?
What coordination and supervision steps are required?
Short Vignette B

[NAME] is an 11-year-old whose stepfather takes her to see the caseworker. He is sexually abusing her. He explains to the caseworker that a stranger was seen abusing the private parts of his daughter, and he wants her to get medical treatment only in case she is pregnant or has sexually transmitted diseases. He asks the caseworker not to involve other services except for the doctor. The girl is completely silent during the session and stares at the ground.
Discussion prompts:
What are the immediate safety concerns?
How should caregiver engagement be handled?
What coordination and supervision steps are required?</td></tr>
<tr><td>Plenary debrief</td><td>What tensions do you see between not engaging with perpetrators and respecting the views/ wishes of a child survivor / non-offending caregiver who requests you to do so?
What opportunity do you see for strengthening your boundaries in relation to ensure your caseload of child survivors are protected from further harm presented by perpetrators?
When do you think you may need further guidance or support from your supervisor in relation to navigating issues related to caregivers who are perpetrators?</td></tr>
<tr><td>Additional note to supervisors/ facilitators</td><td>This situation can highlight tensions for non-offending caregivers, as featured in the vignette. This dynamic, and how to work with non-offending caregivers is explored in more detail in a separate session. (See session 10). If there are questions arising about how to address this, take note and be sure to link back to this in the separate session.</td></tr>
</table>

<table>
<tr><td>Topic</td><td>Child sexual abuse cases where the abuser is another child</td></tr>
<tr><td>Definition</td><td>A child is a person under 18 years of age. Child sexual abuse is any form of sexual activity, physical or not, with a child, perpetrated by an adult or by another child who has power over the child. Child sexual abuse often involves body contact, but not always.</td></tr>
<tr><td>Why this can be complex</td><td>Both the harmed child and the child who caused harm are children with rights, needs, and vulnerabilities
Adults may minimize the harm (“children are just curious”) or over-criminalize the behavior
Families may feel shame, anger, or confusion, affecting cooperation
Community responses may increase stigma or retaliation
The behavior may be linked to the child’s own exposure to violence, abuse, or neglect
At the same time, it should be noted that not all sexual activity between adolescents is sexual abuse; caseworkers should be mindful of cases where consensual sexual activity has taken place between older adolescents.
Sexual abuse involves lack of consent, coercion, force, exploitation, or power imbalance.
Cultural taboos or moral concerns do not automatically make consensual adolescent sexual activity abusive.
CCS case management focuses on protection from harm, not enforcing social or moral norms.</td></tr>
<tr><td>Some pitfalls in these cases include…</td><td>Caseworkers may minimize the harm (“children are just curious”) and not assess specific cases on a case-by-case basis.
Caseworkers may pay more attention to a non-offending caregiver who is stating that abuse occurred than an older adolescent who had a consensual sexual encounter.</td></tr>
<tr><td>Caseworkers should be sure to…</td><td>The caseworker should:
Always assess on a case-by-case basis
In cases involving older adolescents make all necessary attempts to ensure that they have the opportunity to speak privately with a caseworker, so that their perspective can be understood as to whether coercion and power was abused or if they provided consent.</td></tr>
</table>

	• Recognize that it can be hard for some older adolescents to admit that they are sexually active to their caregivers due to social and gender norms. Where there is no abuse, the caseworker's role may shift toward: • Providing information and guidance • Supporting communication within families • Referring to appropriate adolescent-friendly or SRH services if relevant
Exercise	**Short Vignette A** [NAME] is a 10-year-old boy who disclosed sexual touching by a 13-year-old cousin during visits to a relative's home. The family insists the behavior was "just children experimenting" and wants the caseworker to handle it informally. The children still see each other regularly. **Discussion prompts:** • What are the immediate safety considerations? • How do we apply best interests of the child for *both* children? • What role does supervision play in deciding next steps? • What coordination or referrals may be required? **Short Vignette B** [NAME] is a 17-year-old girl who was referred to the caseworker after her parents discovered she has been in a sexual relationship with her 17-year-old boyfriend. Both adolescents describe the relationship as mutual and consensual. There are no indicators of coercion, force, significant power imbalance, or distress. The parents are very upset, stating that sex before marriage is unacceptable in their culture and are demanding that the caseworker "take action" against the boy. **Discussion prompts:** • What information is needed to assess whether this situation involves sexual abuse or not? • How do we distinguish between harmful sexual behavior and consensual, age-appropriate sexual activity between adolescents? • How might cultural or community norms influence how this case is perceived? • What is the role of the caseworker when behavior is not abusive but causes family conflict or distress?

	• What supervision support would help a caseworker hold boundaries and support safety in this situation?
Plenary debrief	• What opportunity do you see for strengthening your practice in relation to cases where child survivors experience sexual abuse perpetrated by another child? • When do you think you may need further guidance or support from your supervisor in relation to navigating complexities relating to cases of child sexual abuse perpetrated by another child?

5.3 Debrief *(10 minutes)*

- **ASK** participants if there are any reflections about [insert session topics] that they would like to share with the group before closing
- Close the session by summarizing key reflections, reinforcing links to the CCS Guidelines,
- **ASK** each participant to share one reflection from the session that has stood out most to them/ that they will carry with them

5.4 Session wrap-up *(5 minutes)*

- **ASK** participants to complete the session insights/ evaluation form
- **CONFIRM** date and time of session 6

SESSION 6: COMPLEXITIES RELATING TO CASE MANAGEMENT STEPS AND PROCESS

Session objectives	• To re-cap some of the key issues / complexities that may arise in CCS case management • To provide an opportunity for reflexive practice on navigating two selected complexities within the context
Session Duration:	60 minutes

Session content overview and recommended timings	• Welcome *(5 mins)*
	    o Self-care exercise
	• Key issues and complexities relating to case management process overview (Group select two from list for deeper reflection) *(40 mins)*:
	    o Working with adolescent girls
	    o Working with children with disabilities
	    o Best interests of the child
	    o Mandatory reporting (if applicable)
	    o Information management / information sharing
	    o Caregivers who are perpetrators
	    o Child sexual abuse cases where the abuser is another child
	• Debrief *(10 mins)*
	• Session wrap-up *(5 mins)*

Session materials	Handouts • Session insights/evaluation form
Pre-session reflection / activity for caseworkers	• Ask participants to complete the ranking worksheet one week ahead of time, in order to determine the focus topics for session 5 & session 6
Optional Post-Session Reading	• Chapter 5 of the CCS Guidelines (pages 92-110) • Module 5 of the CCS training package • UNHCR Best Interests Procedure for Refugee and Asylum-seeking Children at Risk (online course): • UNHCR (2021) Best Interests Procedure Guidelines: Assessing and Determining the Best Interests of the Child

Session 6 content

6.1 Welcome *(5 minutes)*

- Welcome the participants to the coaching session
- **SAY** coaching sessions are safe learning sessions where questions and inputs are welcome to support growth and learning
- **ASK** how participants have felt since the last session, if there are any questions or reflections from the previous session that they would like to ask/share
- **EXPLAIN** that today's session will focus on [insert topic based on the pre-session ranking]

DO: Self-care exercise: Micro Movement Break

Guide participants through 20–30 seconds each of:

- Gentle torso twist
- Ankle circles
- Shoulder shrugs
- Slow neck rotation Just enough movement to wake up the body.

This can help stretch out any stiffness or soreness, and invite relaxation into the body ahead of the session. Encourage participants to notice how they feel during the movement and after to 'tune into' their bodies.

6.2 Key issues and complexities relating to case management process *(40 minutes – 20 minutes per topic)*

- **BASED ON RANKING EXERCISE AHEAD OF SESSION 4, SUPERVISORS SHOULD HAVE IDENTIFIED TWO TOPICS TO FOCUS ON IN SESSION 6.**
- **SESSION CONTENT IS ACCESSIBLE FROM SESSION 5. (SEE ABOVE).**

6.3 Debrief *(10 minutes)*

- **ASK** participants if there are any reflections about [insert session topics] that they would like to share with the group before closing
- Close the session by summarizing key reflections, reinforcing links to the CCS Guidelines
- **ASK** each participant to share one reflection from the session that has stood out most to them/ that they will carry with them

6.4 Session wrap-up *(5 minutes)*

- **ASK** participants to complete the session insights/ evaluation form
- **CONFIRM** date and time of session 7

SESSION 7: WORKING WITH NON-OFFENDING CAREGIVERS

Session objectives	• To give participants a clear understanding of when and how to work with non-offending caregivers in alignment with the CCS guidelines. • To provide an opportunity for reflexive practice on how caseworkers are currently engaging with non-offending caregivers and how they can strengthen their practice in this aspect.
Session Duration:	60 minutes
Session content overview and recommended timings	• Welcome *(10 minutes)* o Self-care exercise • Reflection sharing *(15 minutes)* • Activity *(25 minutes)* • Debrief *(5 minutes)* • Session wrap-up *(5 minutes)*
Session materials	Handouts • Handout: Working With Non-Offending Caregivers Vignettes • Session insights/evaluation form

Pre-session reflection / activity for caseworkers	• Pre-session reflection on the following questions:
	  o Have you actively worked with and engaged with non-offending caregivers as part of CCS? Yes/No
	  o If yes, during which steps of case management have you noticed you engaged most with non-offending caregivers? Why do you think this is?
	  o Overall, would you describe your interactions with non-offending caregivers as more positive than negative, mixed overall, or, more negative than positive?
	  o Be able to explain briefly the reason for the rating you have given in the previous question and what may have contributed to/ influenced your perspective on this.

Post-session activity	• Chapter 2 of the CCS Guidelines (pages 49-50) • Chapter 4 of the CCS Guidelines (pages 89-90) • Chapter 5 of the CCS Guidelines (pages 96-100)

	• CCS Guidelines (pages 177-178)

Session 7 content

7.1 Welcome (10 minutes)

- Welcome the participants to the coaching session
- **SAY** coaching sessions are safe learning sessions where questions and inputs are welcome to support growth and learning
- **ASK** how participants have felt since the last session, if there are any questions or reflections from the previous session that they would like to ask/share
- **EXPLAIN** that today's session will focus on working with non-offending caregivers.

DO: Self-care exercise: Self-Compassion

Often, we are harder on ourselves than we are on anyone else. So, for this activity, you will be asked to write a compassionate note to yourself. Imagine that you are talking to yourself like you would talk to a young child. Be accepting and compassionate. Keep in mind how would you reassure this child that he/she/they is/are a valuable, worthwhile, and beautiful human being? In this brief note, just be sure to write to yourself in a way that is compassionate and caring.

How did people choose to show self-compassion?

SAY: Thank you to everyone who participated in this activity! We can now share some self-compassionate statements that people used to make themselves feel better.

Here are some great ways people were self-compassionate:

(**Note to supervisors:** Use the relevant examples from the list below as well as reflecting back any other points people mentioned that stood out to you).

- You are worthy.
- You are deserving of love.
- You are loved.
- No matter what you choose to do in life, it's okay.
- You are amazing.
- You are talented.
- You are perfect just the way you are.
- Don't let anyone bring you down. I believe in you.
- Hang in there.
- It's going to be okay.
- You are strong.
- You are a person with potential.
- You are enough.

SAY: Next time you practice self-compassion, feel free to use these statements to really remind yourself that you're awesome. Try to build this into your self-care practice, it can really help to pick you up in times of struggle or to help maintain a positive self-image.

[Adapted from source: Tchiki Davis, MA, PhD. Self-compassion exercise. Berkeley Wellbeing.]

7.2 Reflection sharing *(15 minutes)*

EXPLAIN that today we will be focusing on working with non-offending caregivers as part of the support we provide as caseworkers to child survivors.

A non-offending caregiver is a parent or caregiver who has not sexually abused or directly participated in the sexual abuse of their child. Caseworkers should engage with non-offending caregivers to the extent feasible in order to support the safety and confidentiality and best interests of the child. They should do so with the knowledge and awareness of the child survivor. When caseworkers work safely and effectively (in line with the guiding principles) with non-offending caregivers it can enhance positive outcomes for the abused child.

DISCUSS the following questions – that were part of your pre-session preparation - and which draw on your practice experience, to-date:

- **ASK:** for a show of hands as to who has actively worked with and engaged with non-offending caregivers as part of CCS? For those that have....
- **ASK:** During which steps of case management have you noticed you engage most with non-offending caregivers? Why do you think this is?
- **ASK** for a show of hands as to who rated their interactions with non-offending caregivers as more positive than negative, mixed overall, more negative than positive?
- **ASK** for 1 volunteer who would like to briefly explain why their interactions were overall more positive than negative and one volunteer who felt their experiences were more negative than positive and what may have contributed to/ influenced their perspective on this.

Note to supervisors: Probe whether participants think unconscious/conscious bias, gender and social norms influenced their views.

Thank participants for sharing their reflections.

7.3 Activity *(25 minutes)*

- **SAY:** Now we are going to do an activity where we will map out together the opportunities we have to strengthen our practice and engage effectively with non-offending caregivers -(considering their strengths)- to seek their participation in the care of their child, following sexual abuse – and throughout the case management process.

Supervisor note: Supervisors also have the option to contextualize these vignettes further or substitute them for anonymized vignettes more closely aligned to recent cases their organization has handled and to split the participants into smaller groups to work on different or the same vignettes depending on the group needs.

DO: Working With Non-Offending Caregivers Vignettes Activity

Purpose of the Activity

This activity helps participants identify practical opportunities to engage and strengthen the involvement of non-offending caregivers throughout the case management process.

The objective of this activity is to consider key opportunities to engage with non-offending caregivers with the primary objective of supporting the care of their child AND secondarily to support their strengths and capacities to protect and support their child.

Instructions

1. Introduce the activity and explain that participants will map opportunities to effectively engage non-offending caregivers using one or more provided vignettes (depending on time).
2. Distribute the *Working With Non-Offending Caregivers Vignettes* handout.
3. Ask participants to read their assigned vignette(s). (2-3 minutes).
4. In small groups or individually, have participants complete the table on the *Mapping Potential Opportunities to Engage with Non-Offending Caregivers* handout identifying key engagement points and strategies (20 minutes).
5. Invite questions before starting and remind participants they may seek guidance during the activity.
6. Reconvene to briefly share key reflections and approaches identified.

Handout: Working With Non-Offending Caregivers Vignettes

Vignette 1: [NAME] is a 12-year-old boy who experienced sexual abuse by someone known to the family. He lives with his father, who believes him but feels unsure how to support him. He reports sudden episodes where his heart races and he feels short of breath, especially when he is alone or reminded of the abuse. He avoids going outside and prefers to stay close to his caregiver.

Vignette 2: [NAME] is a 14-year-old girl who has been sexually abused by her father over a period of 3 years. Her mother has also been sexually abused and experiences physical violence from her husband. [NAME] has missed her period, and her mother is concerned that she may be pregnant; both are fearful and afraid of further violence. Her mother mentions that they both feel hopeless in the situation and just want to 'escape this life'.

Vignette 3: [NAME] is a 16-year-old girl who disclosed sexual abuse by an older man. Community leaders are pressuring her family to agree to a marriage to "resolve the situation." She says she feels angry but also worried about causing problems for her parents. She appears calm during sessions but avoids discussing the future.

Vignette 4: [NAME] is a 9-year-old whose stepfather is the alleged perpetrator. The child's mother is conflicted and asks the caseworker not to involve other services. The child appears withdrawn and anxious during sessions.

Vignette 5: [NAME] is a 13-year-old adolescent girl whose father is the alleged perpetrator. The child's mother is blaming her daughter and protecting the perpetrator by denying he is responsible. The adolescent girl is pleading with her mother during sessions for her to stop defending him and to support her to live free from violence and abuse.

Discussion prompts:

- What are the immediate safety concerns?
- How should caregiver engagement be handled?
- What coordination and supervision steps are required?

Handout: Mapping potential opportunities to engage with non-offending caregivers			
Case management step	**I have the opportunity to engage the non-offending caregiver when….**	**I could say this […] to the non-offending caregiver during this step**	**In order to support the child survivor and/or the non-offending caregiver with….**
Step 1: Introduction and engagement			
Step 2: Assessment			
Step 3: Case Action Planning			
Step 4: Implement Case Action Plan			
Step 5: Follow-up			
Step 6: Closure and Evaluation			

7.4 Debrief (5 minutes)

- **ASK** for 1 or 2 volunteers to briefly summarize their overall takeaways from this activity and how they will apply what they picked up from this activity.
- **ASK** participants if there are any reflections about working with non-offending caregiver that they would like to share with the group before closing
- Close the session by summarizing key reflections, reinforcing links to the CCS Guidelines

EXPLAIN: The key messages relating to working with non-offending caregivers:

- A reminder that: a guiding principle of CCS is to prioritize the physical and emotional safety (short- and long-term) of the child survivor of sexual abuse and support non-offending caregivers and family members when seeking services.
- A child-centered approach seeks to explore and build on a child's protective factors and address risk factors, including the child's and non-offending caregivers' strengths.
- Child survivors and their non-offending caregivers are the experts on their own lives and have the right to participate in decisions that affect their lives.
- Caseworkers may also identify situations where a non-offending caregiver needs case management services. Particularly when non-offending caregivers need services as well, the need for case consultations and case coordination increases.
- In situations of co-occurring violence, caseworkers will need to provide referrals to any additional family members disclosing other forms of violence. For example, if the female caregiver of a child survivor discloses intimate partner violence, she should be offered a referral to a GBV caseworker, one that is separate from the caseworker already working with the child survivor so that the caregiver can receive dedicated survivor-centered support.
- Non-offending caregivers should be treated with respect, dignity and compassion throughout the case management process.
- The right to non-discrimination applies to non-offending caregivers regardless of caseworker beliefs and biases whether conscious or unconscious.
- Non-offending caregivers may request mediation, couples counselling or family-based therapy interventions. This does not mean that these services should or must be provided by your organization. It is important to provide non-offending caregivers with accurate information about the services which your organization provides, how it provides these and the risks and benefits associated with these. To note: The Inter-agency GBV Guidelines do not recommend mediation in IPV cases.
- Some caregivers may not participate in case management processes in ways which are supportive of / or which center the child survivor. They may be ambivalent / conflicted about engaging in the process and supporting the child. They may even be protective of the perpetrator (e.g., denying that they could be

responsible) and unsupportive, (even blaming or shaming) the child. Both of these reactions are common as child abuse can be hard to process.

It is important that caseworkers **always** prioritize survivor-centered care and the best interests of the child **first**. Engaging non-offending caregivers can be a process, providing clear information to caregivers about why it is necessary for children's needs to be the focus is important over other interests / priorities.

Some caregivers may consequently shift their position and become less resistant or neutral and more supportive of the child over time, **however, caseworkers must be prepared for the fact that some caregivers may hold to their position and a perspective which does not align with a child and survivor-centered approach, and so, they will need to take necessary steps to protect the child over engagement with the non-offending caregiver**. This may mean identifying another trusted adult in the child's life who can act as their guardian/caregiver -provided they can act in the best interests of the child - or, the caseworker / caseworker supervisor assuming this role.

- **ASK** each participant to share one reflection from the session that has stood out most to them/ that they will carry forward with them.

7. 5 Session wrap-up *(5 minutes)*

- **ASK** participants to complete the session insights/ evaluation form
- **CONFIRM** date and time of session 8.

SESSION 8: MHPSS ASSESSMENT

<table>
<tr><td>Session objectives</td><td>To give participants a clear understanding of the importance and necessity of effective MHPSS assessment when working with child survivors
To provide an opportunity for reflexive practice on MHPSS assessments and supporting MHPSS needs of child survivors.</td></tr>
<tr><td>Session Duration</td><td>60-90 minutes (approximation depending on the length of time needed for the stigma conversation).</td></tr>
<tr><td>Session content overview and recommended timings</td><td>Welcome (5 mins)
Self-care exercise
What is effective MHPSS assessment? (7 mins)
Coordination implications (3 mins)
Reflective practice strengthening MHPSS assessment skills (30 mins)
Debrief (5 mins)
Session wrap-up (5 mins)</td></tr>
<tr><td>Session materials</td><td>Handouts
Print outs of the exercise vignettes
Contextualization note: Supervisors should amend the vignettes by adding locally used names. Try to avoid using the names of staff members who are in the session.
Copy of CCS MHPSS Assessment Tool per person
Session insights/evaluation form</td></tr>
<tr><td>Pre-session reflection / activity for caseworkers</td><td>Watch the PSS Assessment for Child Survivors video (21 mins)
Read through the CCS MHPSS Assessment Tool in the Guidelines (pages 137-146)</td></tr>
<tr><td>Optional Post-Session Reading</td><td>CCS Guidelines (pages 139-166)
CCS Training Package Module 6B</td></tr>
</table>

Session 8 content

8.1 Welcome *(5 minutes)*

- Welcome the participants to the coaching session
- **SAY** coaching sessions are safe learning sessions where questions and inputs are welcome to support growth and learning
- **ASK** how participants have felt since the last session, if there are any questions or reflections from the previous session that they would like to ask/share
- **EXPLAIN** that today's session will focus on mental health and psychosocial support (MHPSS) and the MHPSS assessment tool

DO: Self-care exercise: Controlled Belly Breathing

Controlled belly breathing is an exercise that the CCS Guidelines suggest as an example of relaxation training, a helpful MHPSS intervention. Relaxation training teaches children ways to cope with stress and reduce physiological symptoms such as racing or pounding heart, difficulty sleeping or concentrating, anger, anxiety, etc.

- Start off in a comfortable position, either sitting up straight or lying down on your back
- Put your hands on your belly and inhale slowly and deeply for four seconds. You should feel your stomach moving out as you suck in the air, like a balloon. If your breath is still in your chest, it's too shallow.
- Hold the breath for four seconds, keeping the belly balloon as big as possible
- Slowly exhale the air out. If there is any difficulty exhaling slowly, pretend you are breathing through a straw to control the breath.
- Repeat the cycle a few times.

8.2 What is effective MHPSS assessment? *(7 minutes)*

EXPLAIN: In the CCS guidelines, effective MHPSS assessment is not diagnosis and does not require specialist mental health training. It is a structured way of understanding how a child is coping emotionally and psychosocially, so that caseworkers can:

- Respond appropriately
- Monitor changes over time
- Decide when additional support or referral may be needed

Supervisors should reinforce that effective MHPSS assessment:

- Is child-centered and strengths-based
- Looks at feelings, behaviors, and daily functioning
- Recognizes that distress is a normal response to sexual abuse
- Is ongoing, not one-off

- Is documented using the MHPSS assessment tool to support consistency and supervision

ASK What can make MHPSS assessment challenging in our context?

Note on Stigma	**If stigma is well understood by the participants, the supervisor can skip this exercise.** However, if it emerges as a recurring challenge to effective MHPSS assessment, it is poorly understood, or there is misunderstanding of how deeply stigma can impact case management, supervisors are encouraged to spend time discussing how stigma can manifest and why it can impact MHPSS assessments. Use this table to guide a discussion with the group, or individual participant.	
What are the types of stigma? Who is affected?	**How can stigma manifest?**	**What are the implications of stigma for MHPSS Assessment?**
1. Stigma Experienced by Children	Children may: feel shame or self-blame; fear not being believed; worry about bringing trouble to their family; withdraw or avoid discussing the abuse; minimize what happened; show anger or behavioral changes instead of verbalizing distress.	• Emotional distress may be underreported or misunderstood • Children may appear "coping" while masking anxiety, depression, or trauma symptoms • Assessments may require more time, trust-building, and child-friendly approaches • Non-verbal cues and behavior changes must be carefully observed
2. Stigma from Caregivers and Families	Caregivers may: discourage disclosure to protect family reputation; blame the child; pressure the child to stay silent; prioritize family unity or financial stability over safety; deny or downplay the abuse; avoid	• Caregivers may minimize or contradict children's distress • Consent for services may be delayed or withdrawn

	seeking MHPSS support due to fear of community judgement.	• Information gathered may be incomplete or biased • Engagement strategies must address caregiver fears and beliefs to ensure accurate assessment
3. Stigma Held by Caseworkers (Often Unintentional)	Caseworkers may: make assumptions about credibility based on age, gender, disability, or behavior; interpret calm presentation as absence of harm; avoid sensitive questions due to discomfort; prioritize procedural steps over emotional assessment; hold cultural or moral biases that affect judgement.	• MHPSS tools may be used superficially or inconsistently • Key trauma symptoms may be overlooked • Assessments may reflect bias rather than the child's lived experience • Ongoing supervision and reflective practice are critical to ensure objective, child-centered assessment

DISCUSS the MHPSS Assessment Tool for Child Survivors which participants were asked to review prior to the session. Use the following questions as prompts for the discussion:

- **When to use the MHPSS Assessment Tool?**
  - After immediate health and safety needs have been met.
- **Why do we use it? To:**
  - Assess MHPSS needs, problems, and existing worries
  - Develop well rounded sense of support in child's life
  - Develop understanding of child's current functioning and parent/caregiver concerns
  - Develop action plan specific to psychosocial needs
- **How does it impact the services we provide? It**
  - Informs us of the specific needs, priorities, support, strengths, and areas of need for individual survivors.
  - Allows caseworkers to better tailor:
    - The PSS interventions used in the case management process
    - The referrals to other services for the survivor
    - The support and referrals for parents/non-offending caregivers

DISCUSS participants' experience of using the tool, or a similar equivalent if adapted:

- How have you found the tool?
- Are there sections of the tool you find easier to use? More challenging?
    - General assessment; Family and Social Context; Overall Functioning; Caregivers' Feelings and beliefs; Child and Family Strengths
- Which areas of the MHPSS assessment do you need more support with?

Reinforce that: the tool is meant to support conversation, not replace it; not all children will show the same reactions; and there are no 'right' or 'wrong' answers, only observations and reflections.

Supervisors should reinforce that MHPSS assessment:

- Is continuous across the case management process
- Relies on observation, listening, and gentle enquiry, not clinical tools alone
- Must be child-centered, non-judgmental, and strengths-based
- Requires supervision support, particularly for high-risk or confusing presentations

Assessing mental health and psychosocial needs is not a one-time event, but an ongoing, reflective process embedded throughout the CCS case management steps.

8.3 Coordination Implications *(3 minutes)*

EXPLAIN: Effective MHPSS assessment supports:

- Appropriate and safe referrals to specialized services
- Clear information sharing, respecting consent and confidentiality
- Reduced duplication or re-traumatization across services

Poor or inconsistent assessment can lead to:

- Missed risk indicators
- Delayed or inappropriate referrals
- Increased harm or disengagement

ASK if there are any questions regarding the link between MHPSS assessments and coordination.

8.4 Reflective practice strengthening MHPSS assessment practice *(30 minutes)*

EXPLAIN: Supervision and group coaching create essential space for caseworkers to reflect on:

- How comfortable they feel assessing emotional distress
- How personal reactions or fear of "getting it wrong" may affect assessment
- How workload or time pressure influences follow-up

- When and how to seek support for high-risk or complex cases

The majority of today's session will focus on practicing MHPSS assessments, and providing one another feedback to collectively strengthen our practice in this area.

DO Vignettes: Practice using the MHPSS Assessment Tool

Purpose of the Activity

To support caseworkers in recognizing MHPSS indicators, using the MHPSS assessment tool and reflecting on assessment responses without judgement.

Instructions

- Divide participants into small groups (max. 3 persons).
- Hand out copies of the MHPSS assessment tool
- Give each group one vignette at a time.
- Ask groups to:
    - Read the vignette together
    - Work through the MHPSS assessment tool as if this were a real case
    - Agree on what they would record and why
- Remind participants that not every section of the tool will be completed in the same way for every child. The goal is to practice thinking through the tool, not filling every box.
- The supervisor will come around the groups and check how the activity is going, answering questions as needed
- **Supervisor note:** If you are working with a small number of participants, assign vignettes based on priority areas for development. In one-to-one coaching, there should be sufficient time to complete two vignettes.

Vignette 1: [NAME] is a 7-year-old girl who was referred to you by her teacher after changes were noticed in her behavior. Her caregiver reports that she has frequent nightmares and wakes up crying. At school, she has difficulty concentrating and often appears tired. During sessions, she is polite but struggles to talk about her feelings and often says she "doesn't remember" when asked about recent events.

Vignette 2: [NAME] is a 12-year-old boy who experienced sexual abuse by someone known to the family. He lives with his parents, who believe him but feel unsure how to support him. He reports sudden episodes where his heart races and he feels short of breath, especially when he is alone or reminded of the abuse. He avoids going outside and prefers to stay close to his caregiver.

Vignette 3: [NAME] is a 5-year-old girl who was brought to you by her grandmother. The grandmother reports that the child has become very clingy and cries when separated from her. During sessions, the child plays quietly and avoids eye contact. At times, she becomes upset without an obvious reason and needs comfort to calm down.

Vignette 4: [NAME] is a 15-year-old boy who has been receiving your support for several months. He attends sessions regularly but often says he feels "numb" and disconnected. His caregiver reports that he no longer enjoys activities he used to like and spends a lot of time alone. He attends school but has had a drop in performance and motivation.

Vignette 5: [NAME] is a 10-year-old girl with a physical disability that limits her mobility. Her parents are supportive and accompany her to sessions. She appears cheerful at first but becomes quiet when discussing school or peers. Her parents report that she worries about being teased and has difficulty sleeping before school days.

Vignette 6: [NAME] is a 14-year-old girl who disclosed sexual abuse to a trusted friend before being referred. Her family believes her but there is tension in the household due to community stigma. She reports feeling anxious, has trouble sleeping, and worries frequently about the future. She continues attending school but avoids social activities and prefers to be alone.

Supervisor Coaching Prompts

In case needed, the following prompts are available to the supervisor to encourage discussion per vignette:

Vignette 1:

- Which signs suggest emotional distress rather than behavioral problems?
- How would you record uncertainty or "not remembering" in the tool?
- What changes over time would you want to monitor?
- How might this assessment inform follow-up or coordination?

Vignette 2:

- How does the tool help distinguish distress from immediate risk?
- What language would you use to record panic symptoms clearly and calmly?
- How might this assessment inform follow-up or coordination?

Vignette 3:

- How do you capture emotional responses in younger children using the tool?
- What observations are more useful than direct questioning at this age?
- How might this assessment change over time?
- How might this assessment inform follow-up or coordination?

Vignette 4:

- How does the tool help track changes over time?
- How would you record "numbness" without interpreting or diagnosing?
- What strengths or protective factors might still be present?
- How might this assessment inform follow-up or coordination?

Vignette 5:

- How does the tool support disability-inclusive assessment?
- What assumptions should be avoided when recording MHPSS needs?
- How might school-related anxiety show up in other sections of the tool?
- How might this assessment inform follow-up or coordination?

Vignette 6:

- How does context (family/community) influence MHPSS assessment?
- How can the tool help balance distress and strengths?
- What information would be important to review again in follow-up?
- How might this assessment inform follow-up or coordination?

8.5 Debrief *(5 minutes)*

- **ASK** participants if there are any reflections about MHPSS assessment and the tool that they would like to share with the group before closing
- Close the session by summarizing key reflections, reinforcing links to the CCS Guidelines
- **EXPLAIN**:
    - MHPSS assessment helps us understand how children are coping, not label them
    - Assessing mental health and psychosocial needs is not a one-time event, but an ongoing, reflective process embedded throughout the CCS case management steps.
    - Stigma can silence distress. MHPSS assessment helps us listen more carefully to children, caregivers, and ourselves.
    - Roleplay and reflection help identify habits that may unintentionally impact MHPSS assessment and children
    - Using the tool well supports safer coordination and better care for children
- **ASK** each participant to share one reflection from the session that has stood out most to them/ that they will carry with them

8. 6 Session wrap-up *(5 minutes)*

- **ASK** participants to complete the session insights/ evaluation form
- **CONFIRM** date and time of session 9

SESSION 9: HIGH RISK/ COMPLEX MHPSS ASSESSMENT

Session objectives	• To provide an opportunity for reflexive practice on attitudes/ myths/ stereotypes existing within the context regarding suicide and self-harm. • To affirm the caseworker's role in providing non-judgmental support to child survivors who are having suicidal thoughts or using self-harm coping strategies. • To provide an opportunity for reflexive practice on how and when to refer survivors for MHPSS support and what support may be available within the context.
Session Duration	60-90 minutes

Session content overview and recommended timings	• Welcome *(5 mins)*
	  ○ Self-care exercise
	• High risk/Complex MHPSS cases *(15 mins)*
	  ○ Panic attacks
	  ○ Flashbacks
	  ○ Suicide and self-harm
	• Reflective practice strengthening MHPSS assessment skills *(30 mins)*
	• Debrief *(5 mins)*
	• Session wrap-up *(5 mins)*

Session materials	Handouts • Print outs of the exercise vignettes Contextualization note: Amend the names of the children in the vignettes if the ones provided do not fit to your context. Try to avoid using the names of supervisee(s) attending the session • Session insights/evaluation form
Pre-session reflection / activity for caseworkers	• Ask participants to watch the role play video on suicide risk assessment before the session • Supervisors should make sure that they are available to support caseworkers with high risk and complex cases and should ensure that there is always someone on staff that has been trained in how to carry out suicide/ self-harm assessments. It could be helpful to ask this staff member to

	join the coaching session to support answering questions and providing support.
Optional Post-Session Reading	• CCS Guidelines (pages 139-166) • CCS Training Package Module 6B

Session 9 content

9.1 Welcome *(5 minutes)*

- Welcome the participants to the coaching session
- **SAY** coaching sessions are safe learning sessions where questions and inputs are welcome to support growth and learning
- **ASK** how participants have felt since the last session, if there are any questions or reflections from the previous session that they would like to ask/share
- **EXPLAIN** that today's session will continue focusing on mental health and psychosocial support (MHPSS) and specifically high risk and complex cases, including suicide and self-harm risk assessments
    - Acknowledge that suicide and self-harm can be difficult to talk about
    - Emphasize that sharing is voluntary
    - Reinforce confidentiality within the group
    - Remind participants that supervision is the place to bring uncertainty and concern

Supervisor note: This session does not aim to make caseworkers mental health specialists. It reinforces their role in recognition, assessment, documentation, and referral, with supervision as a core safety mechanism.

DO Self-care exercise: 5-4-3-2-1 Grounding method
We will begin with another relaxation technique which can be used with child survivors, similar to the last session, this techniques can teach children ways to cope with stress and reduce physiological symptoms such as racing or pounding heart, difficulty sleeping or concentrating, anger, anxiety, etc. The 5-4-3-2-1 method involves using the 5 senses to observe your environment, which helps interrupt anxious thoughts. Here's how it works: Identify 5 things you can see, 4 things you can feel, 3 things you can hear, 2 things you can smell, and 1 thing you can taste. • **Step one: 5 things you can see** - Look around and identify five things. For example, a red book on the table, a clock on the wall, a painting, the window outside, and a chair across the room.

- **Step two: 4 things you can touch** - Focus on four objects you can physically feel. Maybe it's the softness of your sweater, the smoothness of your pen, the coolness of the chair beneath you, and the warmth of a mug in your hand.
- **Step three: 3 things you can hear** - Listen for three different sounds. You might hear the ticking of a clock, the hum of the air conditioner, and someone talking in the background.
- **Step four: 2 things you can smell** - Notice two scents around you. Maybe it's the scent of fresh rain outside and the faint scent of food cooking in the kitchen.
- **Step 5: 1 thing you can taste** - Pay attention to the taste in your mouth, whether it's the lingering flavor of your lunch or just the natural taste of your mouth.

9.2 High risk and complex MHPSS cases *(15 minutes)*

EXPLAIN: This session supports caseworkers to build confidence in recognizing and responding to high-risk and complex MHPSS presentations in child survivors. The session clarifies key concepts, reinforces that children may show distress in different ways, and strengthens skills in responding to suicide and self-harm risk using CCS tools, supervision, and referral pathways.

High-risk and complex MHPSS cases are those where:

- A child's distress is intense, persistent, or worsening, or
- There are indicators of self-harm or suicide, or
- Multiple stressors (e.g. ongoing risk, stigma, disability, isolation) interact

Emphasize:

- Not all children show distress in the same way
- Quiet, withdrawn children can be at high risk
- Behavior that looks "difficult" may reflect distress

Support is always available

- High-risk cases require immediate consultation
- Documentation protects the child and the caseworker
- Coordination must follow consent, confidentiality, and safety principles
- Caseworker wellbeing matters when managing high-risk situations

ASK in your experience, what are some examples of high risk and complex MHPSS cases?

EXPLAIN the guidelines cover flashbacks and panic attacks, let's take a moment to review these.

DISCUSS:

- What is a flashback? How does it present?
- What is a panic attack? How does it present?

- Do these always manifest in the same way? Do all children behave the same when experiencing a flashback or a panic attack?
- In your experience, have you worked with clients who have had a flashback or panic attack? Without sharing identifying information, how did it make you feel?

For reference to the supervisor facilitating the session:

Form	**Definition/ Manifestation**	**Notes for supervisor to emphasize**
Flashbacks	Flashbacks are trauma responses where a child may feel as though the abuse is happening again. They may appear: • Distant, frozen, or unresponsive • Highly distressed, panicked, or confused • Tearful, shaking, or clinging	Flashbacks are not misbehavior or resistance.
Panic Attacks	Panic attacks involve intense fear and physical symptoms such as: • Rapid breathing or heart rate • Dizziness or chest pain • Fear of losing control or dying	Panic can happen suddenly and may be triggered or untriggered.

Focusing on Self-Harm and Suicide Risk

Children and adolescents may experience and express self-harm and suicide risk in different ways. There is no single or "typical" presentation.

- Children and adolescents may express risk in different ways:
  - Direct statements ("I want to hurt myself")
  - Indirect comments ("I wish I wasn't here")
  - Behavior changes (e.g. Aggression, withdrawal, risk taking)
  - Withdrawal or numbness
- Risk may:
  - Change over time
  - Increase during stress or transitions
  - Be hidden due to shame or fear

In line with the CCS Guidelines, caseworkers are responsible for recognition, assessment, documentation, and referral, with supervision as a core safety mechanism.

Where a caseworker:

- Does not have experience in suicide risk assessment, or

- Identifies indicators of high or complex risk

they must:

- Consult their supervisor immediately, and
- Refer to MHPSS specialists or others trained in suicide risk assessment

DISCUSS:

- What feelings come up when we think about suicide or self-harm in children or adolescents?
- What myths exist (e.g. “talking about suicide causes it” or “they are just seeking attention”)?
- How might fear or stigma stop us from asking direct questions about self-harm or suicide?
- How does a non-judgmental approach protect children?
- What signs tell you a case has moved beyond your role and requires specialist support?
- How does supervision help you hold appropriate boundaries in high-risk cases?

For reference to the supervisor facilitating the session:

Form	Definition/ Manifestation	Notes for supervisor to emphasize
Self-Harm	Self-harm refers to intentional injury to oneself as a way to cope with distress (e.g. cutting, scratching, burning).	• Self-harm is a coping strategy, not attention-seeking • It can exist with or without suicidal intent
Suicide	Suicide risk includes thoughts, plans, or behaviors related to ending one’s life.	• Talking about suicide does not cause it • Risk can be expressed directly or indirectly

DISCUSS: Ahead of today’s session, you were asked to watch the CCS role play video on suicide risk assessment, let’s take a moment to discuss the video:

- How did the video make you feel?
- What stands out to you from the video?
- What communication techniques did you notice from the video?
- Are there any techniques from the video that would/ would not work in our context? Why/ why not?

- Are there any techniques from the video you would like to try in your practice? Why/ why not?

9.3 Reflective practice strengthening MHPSS assessment practice *(30 minutes)*

EXPLAIN: Supervision and group coaching create essential space for caseworkers to reflect on:

- How comfortable they feel assessing emotional distress
- How personal reactions or fear of "getting it wrong" may affect assessment
- How workload or time pressure influences follow-up
- When and how to seek support for high-risk or complex cases

Similar to the last session, most of today's session will focus on practicing MHPSS assessments, and providing one another feedback to collectively strengthen our practice in this area.

DO: Vignettes: MHPSS practice

Purpose of the Activity

To support caseworkers in recognizing MHPSS indicators and reflect on assessment responses without judgement.

Instructions

- Divide participants into small groups.
- Hand out copies of the printed vignettes
- Ask groups to:
- Identify immediate safety concerns
- Note what supervision and referral steps may be needed
- Rotate vignettes if time allows.
- The supervisor will come around the groups and check how the activity is going, answering questions as needed

Vignette A:

Child: Mariam, 9
Context: Early engagement stage
Presentation:
During a session, Mariam suddenly becomes silent, stares at the floor, and does not respond when spoken to. After a few minutes, she begins crying and clings to her caregiver. Later, she says she felt like "it was happening again."

Vignette B:

Child: Lina, 15
Context: Approaching case follow-up stage
Presentation:
Lina reports feeling sad some days but says talking to a trusted teacher helps. She attends school regularly and enjoys drawing. One day, her caregiver reports finding messages on her phone where she talks about wanting to disappear. Lina has not said this directly to the caseworker.

Vignette C:

Child: Daniel, 14
Context: Mid-way through case management
Presentation:
Daniel reports sudden episodes where his heart races, he feels dizzy, and he struggles to breathe, especially when thinking about school. He avoids crowded places and says he feels scared "for no clear reason."

Vignette D:

Child: Joseph, 12
Context: Mid-way through case management
Presentation:
Joseph frequently gets into fights at school and is described as "angry" by his caregiver. He says he gets irritated easily and does not like being told what to do. Joseph has scratches on his arms. He says hurting himself helps him feel calmer when he is stressed. He has not told anyone else. He sometimes refuses to attend sessions.

Supervisor Coaching Prompts

In case needed, the following prompts are available to the supervisor to encourage discussion per vignette:

- What signs suggest different levels of risk?
- What protective factors are present?
- At what point is immediate supervision required?

9.4 Debrief *(10 minutes)*

- **ASK** participants if there are any reflections about high risk/ complex cases that they would like to share with the group before closing.
- **Reinforce that no caseworker manages suicide risk alone and that supervision and referral pathways are essential.**
- **DISCUSS** the following questions to support debriefing:
  - What felt most challenging when using the tool?
  - How did the tool help structure your thinking?

- When would you escalate immediately to a supervisor?
    - What referral pathways are available in your context?
    - How can coordination be done safely and respectfully?
- Close the session by summarizing key reflections, reinforcing links to the CCS Guidelines,.
- **EXPLAIN**:
    - Suicide and self-harm can be discussed calmly and directly
    - The assessment tool supports safe, structured responses
    - Non-judgmental attitudes reduce risk
    - Supervision is essential for high-risk cases
- **ASK** each participant to share one reflection from the session that has stood out most to them/ that they will carry with them

9.5 Session wrap-up (5 minutes)

- **ASK** participants to complete the session insights/ evaluation form
- **CONFIRM** date and time of session 10.

SESSION 10: CASE-LEVEL COORDINATION

Session objectives	• To give participants a clear understanding of the importance and necessity of making relevant, safe referrals when working with child survivors • To provide an opportunity for reflexive practice on when to use case consultation and when to use case conferences for case-level support to child survivors. • To give participants a re-cap on the importance of effective coordination and maintaining guiding principles within case level coordination and identify specific strategies they can use to strengthen case level coordination with relevant actors in their context.
Session Duration:	60 minutes

Session content overview and recommended timings	• Welcome (*5 minutes)*
	  ○ Self-care exercise
	• Coordination terms and their meanings matching game *(15 minutes)*
	• Coordination Practice reflection *(30 minutes)*
	  ○ What challenges do we face in making safe referrals?
	  ○ Case studies – case consultation or case conference?
	• Debrief *(5 minutes)*
	• Session wrap-up *(5 minutes)*

Session materials	Handouts • Coordination terms and their meaning handout. ○ (Facilitators will need to pre-cut the terms and their meanings out and separate and mix them up AND print another full copy for facilitator / supervisor reference). • Coordination case study handout • Handout: *Table 6.3 - Characteristics of case consultations and case conferences* (p.131 of the CCS Guidelines). • Session insights/evaluation form

Pre-session reflection / activity for caseworkers	• N/A
Optional Post-Session Reading	• Chapter 7 CCS Guidelines (pages 167-180) • Chapter 6 CCS Guidelines (pages 129-131) • CCS training package module 7 • Coordination framework for CP and GBV: • Tip sheet for CP and GBV collaboration:

Session 10 content

10.1 Welcome (5 minutes)

- Welcome the participants to the coaching session
- **SAY** coaching sessions are safe learning sessions where questions and inputs are welcome to support growth and learning
- **ASK** how participants have felt since the last session, if there are any questions or reflections from the previous session that they would like to ask/share
- **EXPLAIN** that today's session will focus on coordination – at the case level

DO: Self-care exercise: Let's investigate together some ways in which we can build in self-care at work?

How can we incorporate self-care at work? [Discuss and take notes as a supervisor so you can put these ideas up in the office to remind caseworkers]

EXPLAIN For those working to address violence against women and violence against children, self-care in the workplace might look like?

- Leaving enough time in between appointments with clients to allow yourself space to regroup and ground yourself
- Celebrating our achievements and rewarding ourselves for having completed a difficult task
- Scheduling walking meetings outside of the office or your home to give yourself a change of scene
- Putting up beautiful images, artwork, quotes and things that inspire you around your workspace
- Asking for help when you need it
- Ending each day by reminding yourself of two things you have done well, and two things you are grateful for

[Source from SVRI's *Dare to Care Wellness Course*, Module 2].

10.2 Coordination terms and their meaning – matching game *(15 minutes)*

DO Matching Game Exercise

Purpose of the Activity

This activity builds shared understanding of key coordination terms used in our work. It helps clarify meanings, address misconceptions, and strengthen consistent, confident practice.

Instructions

1. Begin by explaining that the session will focus on clarifying common terms used in case coordination and that this is a safe space for learning and discussion.
2. Place the mixed-up coordination terms and their definitions on a table or floor and gather participants around.
3. Ask participants to match each term with its correct meaning, encouraging them to discuss their reasoning as they work.
4. Once completed, review each term together and clarify or correct any misunderstandings.
5. Close by asking participants:
    - whether they found the exercise easy or hard? What was easy? What was hard about it?
    - Were any of the terms or answers new to them?
    - Were any of the answers surprising to them?
    - what they found easy or challenging and whether any terms or meanings were new or surprising.

Handout: Coordination terms and their meaning	
Term	**Meaning**
Case Coordination	Refers to a structured approach to cases, ensuring that survivors receive comprehensive support and services. This includes coordinating various services such as health, legal and educational support to ensure child survivors have access to necessary resources. Ensuring effective communication and collaboration among service providers to bridge gaps and improve outcomes for survivors is also part of coordination. A coordinated approach is essential for providing safe and effective responses to child survivors.
Case conference	An opportunity for multiple service providers to review case plans for complex and/or high-risk cases.
Case consultation	A process for seeking support and guidance from a supervisor, senior caseworker or another provider on a particular issue in a case.
Referral (agency not self)	A process whereby a survivor can, with the support of a caseworker be given clear, accurate information about services which are relevant to their needs and given the choice to give informed assent/consent to receive those services and what specific information relating to them will be shared with that service provider by the caseworker. Once this is ascertained the caseworker will then contact the service provider to arrange for them to provide the service to the survivor (with or without their accompaniment).
Referral pathway	Provides information about the various service providers in the community, what services they provide, and who the focal point is for referrals for each service provider so that it is clear what the pathway to care is for child survivors and how they can access the available support.

10.3 Coordination practice reflection *(30 minutes)*

ASK participants to briefly share why they think coordination is important?

EXPLAIN that effective coordination can mitigate the risk of:

- contradictory or confusing information to the child and/or their caregivers;
- re-experiencing the distress of the abuse due to multiple interviews;
- loss of trust in the service providers and their capacity to assist;
- delays in services provision that have lasting impacts on the child;
- having limited access to and choice in service provider.

EXPLAIN to participants that we will now spend 30 minutes reflecting on our current case coordination practices and how these could be further strengthened.

- **SAY:** First, let's begin by spending 15 minutes looking at how and when we need to make **referrals to other agencies / service providers?**
- **ASK:** What issues do we notice in relation to these?
- Supervisors may wish to use the following prompts to guide the referral discussion, **ASK**:
    - What challenges do we face in making referrals? Are there any specific sectoral referrals which are particularly challenging? Why is this this? When listening to your supervisee(s) take notes of what their concerns are, explain that you are taking notes so that you can reflect further after today's session on these challenges to support further collective action. Also, pay careful attention to what are case-related issues and what are system-related coordination challenges which need to be addressed through the relevant interagency coordination mechanism.
    - Do we have any safety concerns / notice any risk-related concerns when making referrals? What are these? When do these arise? What can we do to reduce these risks?
    - How do you currently review / assess whether a referral was safe for a child survivor you are working with? What sources of information do you use to determine this? Prompt here as to whether or not the caseworkers ask the child and the non-offending caregiver about whether they were i) able to access services from the referral agency and ii) how the process was for them? Caseworkers should also enquire whether children need any additional support to feel more comfortable with the referral? E.g. accompaniment, transportation support.

After 15 minutes, **SUMMARIZE** the key takeaways and actions which have surfaced in relation to supporting practice improvements relating to safe referrals for individual child survivors.

- **EXPLAIN** that we will now shift our focus, for the next 15 minutes, to thinking about when and how we use case consultation and when and how we use case conferences.

DO: Coordination Case Study Exercise

Purpose of the Activity

This activity helps participants distinguish between case consultation and case conferencing and identify when each approach is most appropriate. It strengthens decision-making around effective case coordination.

Instructions

1. Explain that the group will spend the next 15 minutes focusing on when and how to use case consultation versus case conferencing.
2. Distribute the **coordination case study handout** and ask participants to work individually or in pairs to decide whether each scenario calls primarily for case consultation or case conferencing (allow no more than 5 minutes).
3. Reconvene as a full group and invite a volunteer to share their decision for Case Study 1, briefly explaining their reasoning (1–2 minutes).
4. Ask others to indicate whether they agree or disagree (e.g., by a show of hands)
5. Repeat this process for Case Studies 2 and 3, inviting different volunteers to share each time.
6. Conclude by reinforcing the key distinctions between case consultation and case conferencing identified earlier in the session through the terms and matching definitions exercise.

Coordination Case Study Handout

Case study 1

[Name] is a 14-year-old girl who has been sexually abused by her father over a period of 3 years. Her mother has also been sexually abused and experiences physical violence from her husband. [Name] has missed her period, and her mother is concerned that she may be pregnant; both are fearful and afraid of further violence. Her mother mentions that they both feel hopeless in the situation and just want to 'escape this life'.

Would you use case consultation or case conferencing in this situation?

Why?

Case study 2

[NAME] is a ten-year-old boy who shares a sleeping area with his parents. The space is very small and confined with no privacy screening. [Name] has now started touching and grabbing the private parts of his younger sister [Name] aged six and imitating the sounds he has heard his parents make. His mother has come to see you to understand what to do about his behavior and how to protect her daughter.

Would you use case consultation or case conferencing in this situation?

Why?

Case study 3

[NAME] is an eight-year-old girl with both a sensory and physical disability which means that she cannot speak (although she can make sounds and has cognitive functioning). She also needs to use a wheelchair to support her mobility or is otherwise bed-bound. [NAME] lives with her uncle and his family because both of her parents died. She is dependent on her uncle who has been sexually abusing her and verbally abusing her. Her older female cousin, 19 years old, has noticed some of the abuse and has bought [name] to your center. The cousin is fearful of her father's reaction if he should learn that she has visited the center with [name]. [NAME] shows visible signs of distress and moans anytime the Uncle's name is mentioned. The cousin thinks [NAME] needs to be re-housed away from her father.

Would you use case consultation or case conferencing in this situation?

Why?

Coordination Case Study – Answer Key for Supervisors

Case study 1

[NAME] is a 14-year-old girl who has been sexually abused by her father over a period of 3 years. Her mother has also been sexually abused and experiences physical violence from her husband. [NAME] has missed her period, and her mother is concerned that she may be pregnant; both are fearful and afraid of further violence. Her mother mentions that they both feel hopeless in the situation and just want to 'escape this life'.

Would you use case consultation or case conferencing in this situation?

Case conference

Why?

This is a case of child sexual abuse and co-occurring intimate-partner violence. There are two survivors who need support: an adolescent girl and her adult mother. The adult mother is also the non-offending caregiver. Each survivor has their own distinct needs requiring multi-agency support. For example, the adolescent girl may need access to health care, counselling and psychosocial support (including an MHPSS assessment). The mother may have physical injuries and clinical care needs that require medical attention as well as counselling and psychosocial support (including an MHPSS assessment). However, there may also be overlapping needs and it may also be in the best interests of the child and the mother to be placed in shelter/re-housed, for example and for the mother to be given livelihoods / skills-building support and for the daughter to have access to education/ life skills sessions. A case conference could be an effective forum in which to gather the relevant professionals together and ensure that there is relevant, timely coordination and data sharing between agencies (which both survivors have consented/ assented to) to prioritize and harmonize care for both the adult and child survivor.

Additional note: Newer, less experienced, and indeed, ALL caseworkers can always seek support from their supervisor through a case consultation prior to a case conference to seek professional guidance and help determine next steps if they are in doubt as to which course of action to take.

Case study 2

[NAME] is a ten-year-old boy who shares a sleeping area with his parents. The space is very small and confined with no privacy screening. [NAME] has now started touching and grabbing the private parts of his younger sister [NAME] aged six and imitating the sounds he has heard his parents make. His mother has come to see you to understand what to do about his behavior and how to protect her daughter.

Would you use case consultation or case conferencing in this situation?

Case consultation (if needed)

Why?

Both the ten-year old boy and the six-year-old girl are children. Given their ages and likely level of maturity it is unlikely that the ten-year old boy is expressing a knowing intent [understanding] to abuse and harm his younger sister, (although, this should be assessed during the case intake and assessment). It is therefore unlikely that this is a case scenario where there will be an ongoing intervention requiring multi-agency intervention. However, a caseworker may wish to consult their supervisor to understand what support can be provided by the caseworker in this situation, to clarify whether this case constitutes child abuse or not, to understand if there are an additional measures that could be put in place to support the family moving forward.

A caseworker may be able to advise the mother on how to speak with her children about what has happened or facilitate discussions between them so that the boy understands that his behavior towards his sister should cease and is only behavior that takes place between adults in a relationship. The caseworker may also be able to support the mother by suggesting some privacy screening e.g. sheeting, suggestions to turn the radio/tv on when her and her husband are intimate or to ensure the children are not at home in such situations.

Additional note: Newer, less experienced, and indeed, ALL caseworkers can always seek support from their supervisor through a case consultation prior to a case conference to seek professional guidance and help determine next steps if they are in doubt as to which course of action to take.

Case study 3

[NAME] is an eight-year-old girl with both a sensory and physical disability which means that she cannot speak (although she can make sounds and has cognitive functioning). She also needs to use a wheelchair to support her mobility or is otherwise bed-bound. [NAME] lives with her uncle and his family because both of her parents died. She is dependent on her uncle who has been sexually abusing her and verbally abusing her. Her older female cousin, 19 years old, has noticed some of the abuse and has bought [NAME] to your center. The cousin is fearful of her father's reaction if he should learn that she has visited the center with [NAME]. [NAME] shows visible signs of distress and moans anytime the Uncle's name is mentioned. The cousin thinks [NAME] needs to be re-housed away from her father.

Would you use case consultation or case conferencing in this situation?

Case conference.

Why?

This is a complex case involving a child survivor with a range of needs. The complexity arises due to multiple factors:

- Sexual abuse has occurred, indicating a need for timely, medical care. It will be necessary to make a safe referral – likely with accompaniment to address these needs.
- Restricted communication capacity of the child survivor– may increase their risk as they are unable to call for help directly. Efforts to communicate and engage the child using techniques which enable their participation must be made. The cousin may have some relevant insights to share on how to communicate effectively with the survivor.
- Restricted mobility of the survivor – this limits the survivor's autonomy within their current living situation and places them at increased risk. The survivor has specialized mobility support needs and access to personal assistive devices.
- The uncle appears to be in the position of guardian. It will be important to understand if there are any other safe and non-abusive adults in the child's life who may be willing and able to take on a guardian / caregiver role. Or, if alternative options may need to be considered.
- The manner of the disclosure and the level of fear and distress of the survivor and the cousin (daughter of the perpetrator). And, a need to understand if there are any other children/adults at risk of harm from the perpetrator.

A case conference may be helpful in this situation to consult with relevant professionals (e.g. medical/clinical, legal experts, social workers, organizations for persons with disabilities, police/law enforcement) to support a determination of the best interests of the child and to support coordinated and timely action, whilst also engaging and seeking the participation of the survivor to the fullest extent possible. Further case conferences may be needed to follow-up and check that all agencies are providing services to the child survivor in a child-centered and child-friendly manner, sharing only relevant information on a need-to-know basis.

Additional note: Newer, less experienced, and indeed, ALL caseworkers can always seek support from their supervisor through a case consultation prior to a case conference to seek professional guidance and help determine next steps if they are in doubt as to which course of action to take.

EXPLAIN that we identified in the terms and matching definitions game earlier that:

Case consultation should be used by caseworkers when they need to seek an individual specific professional perspective on how to support a child survivor.
This is usually a supervisor but can also be another specialized professional, such as a medical expert, shelter provider, legal expert etc.

A case conference should be convened when there is a need to:

- Involve more than one agency/ service provider to meet the needs of a child survivor
- For complex / high risk cases
- Follow-up and check that all agencies providing services to a child survivor are delivering those services in a timely coordinated manner, avoiding duplication

Remember that agencies must only share relevant information on a need-to-know basis to provide effective child-centered care.

Primary caseworkers can use case conferences as an opportunity to disseminate key messages about child sexual abuse and how best to support a child and their caregiver in order to address harmful attitudes and beliefs and provide on-the-job coaching to other actors with less experience in supporting child survivors.

There should NOT be any individuals at the consultation or conference that are not directly involved in the child survivor's case.

DO: Give participants the final handout for this session: Handout: *Table 6.3 - Characteristics of case consultations and case conferences* (for them to use as a reference tool moving forward).

- **ASK** the participants if the explanations provided are clear. Provide clarification where needed.
- **ASK** the participants if there are any outstanding questions or comments in relation to case coordination. Provide responses or, if not sure, say you will look into the issue and revert back to them on that point.

Handout: ***Table 6.3 - Characteristics of case consultations and case conferences*** (p.131 of the CCS Guidelines).

Table 6.3: Characteristics of case consultations and case conferences

Type of meeting	Case consultation	Case conference
What is the purpose?	**To seek support and guidance from a supervisor, senior caseworker or another provider on a particular issue in a case.** Especially useful when the case would benefit from expert consultation that is beyond the scope of the team providing case management.	**To create a regular opportunity for multiple service providers to review case plans for complex and/or high-risk cases.** Can be especially helpful to address situations where a child's needs are not being met; to identify or clarify ongoing coordination issues amongst service providers; and to provide the child with more holistic, coordinated and integrated services.
Who participates?	The child's caseworker, the supervisor and at least one caseworker or supervisor from the other sector.	The child and/or their caregiver (if appropriate), the caseworker, the supervisor and at least one staff member or supervisor from each of the other departments – or organisations – providing services to the child and their family.
	There should NOT be any individuals at the consultation or conference that are not directly involved in the child survivor's case.	
When does it happen?	As often as necessary. Often initiated early in the case management process. Can be particularly helpful when a child and/or their caregiver do not wish to be referred for additional services, but their needs go beyond the expertise of the primary caseworker.	Regularly through the case management process. The primary caseworker, or if needed, a direct supervisor is responsible for scheduling these regular meetings, inviting participants (ensuring sufficient notice), setting an agenda and facilitating the meeting.
Identifying data shared?	No. The case should be discussed in general terms (e.g., "the child", "the female caregiver", rather than names or other identifiers).	Yes, because the survivor and/or their caregiver are present and all participants in the meeting must already be actively involved in the case management process.

10.4 Debrief *(5 minutes)*

- **ASK** participants if there are any reflections about case coordination that they would like to share with the group before closing.
- **ASK** participants if this session resonates with cases they have worked on or are likely to work on.
- Close the session by summarizing key reflections, reinforcing links to the CCS Guidelines.
- **EXPLAIN:**
    - Case coordination is necessary to support a child-centered approach and support timely, coordinated and relevant delivery of services to meet the range of needs a child survivor has. It can support best interest determinations.
    - Case coordination can consist of either case consultations, case conferences or both. The situations when case consultations or case conferences are used have been discussed and clarified within this session.
    - Child survivors and non-offending caregivers can be invited to participate in case conferences to support effective coordination factoring for the needs and wishes of the survivor.
    - Caseworkers should feel free and able to confidentially consult with their supervisors on any cases involving child survivors if it is in order to support a do no harm approach.
- **ASK** each participant to share one reflection from the session that has stood out most to them/ that they will carry with them

10.5 Session wrap-up *(5 minutes)*

- **ASK** participants to complete the session insights/ evaluation form
- **CONFIRM** date and time of session 11

SESSION 11: KEY LEARNINGS SUMMATION / CLOSING SESSION

Session objectives	• To provide an opportunity for review of the coaching program content and ask for peer/facilitator guidance on remaining questions relating to CCS coaching program content • To provide an opportunity for reflexive practice on how to enhance care for child survivors. • To obtain feedback / evaluate the coaching program.
Session Duration:	60 minutes
Session content overview and recommended timings	• Welcome *(15 mins)* ○ Collective care exercise and reflection • Review of sessions 1-10 key messages/ takeaways *(20 mins)* • Participant Questions and Outstanding Issues *(15 mins)* • Session Wrap Up *(10 mins)*
Session materials	Handouts • Coaching feedback form
Pre-session reflection / activity for caseworkers	• Ask participants to reflect on the coaching sessions, and any topics they would like to revisit or review in more detail, submit these requests to the supervisor in advance (i.e. 1 week ahead of session) to provide adequate time to prepare.
Optional Post-Session Reading	• GBV AoR Helpdesk, Tip Sheet: Collective Care (English): • GBV AoR Helpdesk, Annotated Bibliography: Collective Care Processes and Practices (English): • SVRI *Dare to Care Wellness Course*

Session 11 content

11.1 Welcome *(15 minutes)*

- Welcome the participants to the final coaching session
- **SAY** coaching sessions are safe learning sessions where questions and inputs are welcome to support growth and learning

- **ASK** how participants have felt since the last session, if there are any questions or reflections from the previous session that they would like to ask/share
- **EXPLAIN** that today's session will focus on wrapping up the coaching sessions and provide space for final reflections.

DO: Collective care exercise: Superhero Cape

Prepare one flipchart paper per participant, tape and colorful markers.

- Ask participants to each tape a flipchart paper to their shoulders
- Explain this is their superhero cape, and each person is invited to write a compliment or reflection from the coaching session on each other's cape
- After everyone has written on each other's cape, invite participants to remove their capes and read the compliments shared.

Facilitator note: If flipchart paper is unavailable, can adapt using post it notes/ pieces of paper, and ask participants to write one another compliments from the coaching sessions and share them with one another.

11.2 Review of sessions 1-10 key messages/ takeaways *(20 minutes)*

EXPLAIN: This session provides an opportunity for participants to consolidate learning from the CCS coaching program, reflect on how their practice has evolved, and seek peer or facilitator guidance on remaining questions. The session also creates space for collective reflection, wellbeing, and feedback, supporting continuous improvement of CCS practice and the coaching approach.

DO: Activity: What stood out?

Purpose of the Activity

To reinforce core learning and help participants see the connections across sessions.

Instructions

- Display or read out the session titles (1–10).
- In small groups or plenary, ask participants:
- What key message or learning stood out from each session?
- What felt most useful/ relevant in your day-to-day work?

11.3 Participant Questions and Outstanding Issues *(15 minutes)*

EXPLAIN this is now space for unresolved questions, uncertainties, or dilemmas. Participants were encouraged to reflect on this prior to the session and submit questions to the supervisor. Invite participants to raise:

- Questions from any session

- Situations that still feel unclear or challenging

Note to supervisors: Encourage peer responses first, with facilitator input as needed. If questions require follow-up beyond the session, acknowledge this and note them for later support or supervision.

DO: Activity. "Looking Back, Looking Forward"

Purpose of the Activity

To support reflexive practice and help participants identify concrete practice shifts.

Instructions

Ask participants to reflect silently or write:

- One way their practice has changed or strengthened
- One area they still want to develop
- One commitment they want to carry forward in their work with child survivors

Small-group sharing:
Invite participants to share reflections in pairs or small groups.

Plenary (optional):
Invite a few volunteers to share key reflections.

11.4 Session wrap-up (10 minutes)

- **ASK** participants to complete the coaching feedback form, emphasize that honest feedback is encouraged and feedback will be used to strengthen future coaching

MATERIALS

This section contains a list of the materials required to deliver this supervisory support coaching program.

Session	Supervisor Pre-Session Reading /	Participant Pre-Session Materials	Session Materials	Optional Post-Session Reading
Session 1: Introduction to the coaching process & CCS Guiding Principles	• Chapter 1 of the CCS Guidelines (pages 20-25) • Module 1 of CCS training package • Handout 1.1 Guiding Principles of the Caring for Child Survivors Approach	• N/A	• CCS Module 1 handout: Guiding Principles of the Caring for Child Survivors Approach • Case Study: Applying the CCS Guidelines in Practice • Session insights/evaluation form	• Chapter 1 of the CCS Guidelines (pages 20-25) • Module 1 of CCS training package • Handout 1.1 Guiding Principles of the Caring for Child Survivors Approach
Session 2: Child-friendly attitudes in case work	• Chapter 3 of the CCS Guidelines (pages 58-70) • Module 3 of CCS training package	• CCS Attitude Assessment	• Roleplay script • Session insights/evaluation form	• Chapter 3 of the CCS Guidelines (pages 58-70) • Module 3 of CCS training package

Session 3: Communication skills	• Chapter 4 of the CCS Guidelines (pages 71 – 91) • Module 4 of CCS training package • Module 4 Handout – Communication Do's and Don'ts	• CCS Communication Skills Assessment	• Case study scenarios • Session insights/evaluation form	• Chapter 4 of the CCS Guidelines (pages 71 – 91) • Module 4 of CCS training package • Module 4 Handout – Communication Do's and Don'ts
Session 4: Inclusive communication techniques	• Chapter 4 of the CCS Guidelines (pages 71 – 91) • Module 4 of CCS training package • Module 4 Handout – Communication Do's and Don'ts	• N/A	• Roleplay exercise • Session insights/evaluation form	• Chapter 4 of the CCS Guidelines (pages 71 – 91) • Module 4 of CCS training package • Module 4 Handout – Communication Do's and Don'ts
Session 5: Complexities relating to case management steps and process	• Chapter 5 of the CCS Guidelines (pages 92-110) • Module 5 of the CCS training package • UNHCR Best Interests Procedure for Refugee and Asylum-seeking	• Topic ranking worksheet	• Session insights/evaluation form	• Chapter 5 of the CCS Guidelines (pages 92-110) • Module 5 of the CCS training package • UNHCR Best Interests Procedure for Refugee and Asylum-seeking

	Children at Risk (online course): • UNHCR (2021) Best Interests Procedure Guidelines: Assessing and Determining the Best Interests of the Child			Children at Risk (online course): UNHCR (2021) Best Interests Procedure Guidelines: Assessing and Determining the Best Interests of the Child
Session 6: Complexities relating to case management steps and process	• Chapter 5 of the CCS Guidelines (pages 92-110) • Module 5 of the CCS training package • UNHCR Best Interests Procedure for Refugee and Asylum-seeking Children at Risk (online course): UNHCR (2021) Best Interests Procedure Guidelines: Assessing and	• N/A	• Session insights/evaluation form	• Chapter 5 of the CCS Guidelines (pages 92-110) • Module 5 of the CCS training package • UNHCR Best Interests Procedure for Refugee and Asylum-seeking Children at Risk (online course): UNHCR (2021) Best Interests Procedure Guidelines: Assessing and

	Determining the Best Interests of the Child			Determining the Best Interests of the Child

Session 7: Working with non-offending caregivers	• Chapter 2 of the CCS Guidelines (pages 49-50)
	• Chapter 4 of the CCS Guidelines (pages 89-90)
	• Chapter 5 of the CCS Guidelines (pages 96-100)
	• CCS Guidelines (pages 177-178)
		• Pre-session reflection on the following questions:
		  ○ Have you actively worked with and engaged with non-offending caregivers as part of CCS? Yes/No
		  ○ If yes, during which steps of case management have you noticed you engaged most with non-offending caregivers? Why do you think this is?
			• Copy of Handout: Working With Non-Offending Caregivers Vignettes per person
			• Copy of Handout: Mapping potential opportunities to engage with non-offending caregivers per person
			• Session insights/evaluation form
				• Chapter 2 of the CCS Guidelines (pages 49-50)
				• Chapter 4 of the CCS Guidelines (pages 89-90)
				• Chapter 5 of the CCS Guidelines (pages 96-100)
				• CCS Guidelines (pages 177-178)

		◦ Overall, would you describe your interactions with non-offending caregivers as more positive than negative, mixed overall, or, more negative than positive? • Be able to explain briefly the reason for the rating you have given in the previous question and what may have contributed to/ influenced your perspective on this.		
Session 8: MHPSS assessment	• CCS Guidelines (pages 139-166) • CCS Training Package Module 6B	• Read through the CCS MHPSS Assessment Tool in the Guidelines (pages 137-146)	• Adjust the names in the vignettes to match context but not using names of session participants	• CCS Guidelines (pages 139-166) • CCS Training Package Module 6B

			• Print outs of the exercise vignettes • Copy of CCS MHPSS Assessment Tool per person • Session insights/evaluation form	
Session 9: High risk / complex MHPSS assessment	• CCS Guidelines (pages 139-166) • CCS Training Package Module 6B	• Ask participants to watch the role play video on suicide risk assessment before the session • Supervisors should make sure that they are available to support caseworkers with high risk and complex cases and should ensure that there is always someone on staff that has been trained in how to carry out suicide/ self-harm assessments. It	• Adjust the names in the vignettes to match context but not using names of session participants • Print outs of the exercise vignettes • Session insights/evaluation form	• CCS Guidelines (pages 139-166) • CCS Training Package Module 6B

		could be helpful to ask this staff member to join the coaching session to support answering questions and providing support.		
Session 10: Case-level Coordination	• Chapter 7 CCS Guidelines (pages 167-180) • Chapter 6 CCS Guidelines (pages 129-131) • CCS training package module 7 • Coordination framework for CP and GBV: • Tip sheet for CP and GBV collaboration:	• N/A	• Print two copies of the coordination matching terms / meaning hand-out. • Keep one copy complete and untouched. This is for the supervisor to reference at the end of the exercise when checking that terms are accurately matched to their meaning. Cut out the individual terms and definitions from the other copy of the hand-out and mix them up.	• Chapter 7 CCS Guidelines (pages 167-180) • Chapter 6 CCS Guidelines (pages 129-131) • CCS training package module 7 • Coordination framework for CP and GBV: • Tip sheet for CP and GBV collaboration:

			Please in a small bag if you have them to keep safe until the session or fasten with a paper clip and keep somewhere safe and dry. • Copy of coordination case study per person. • Copy of Handout: *Table 6.3 - Characteristics of case consultations and case conferences* (p.131 of the CCS Guidelines). per person. • Session insights/evaluation form	
Session 11: Key learnings summation/ closing session	• CCS Guidelines (re-read key sections relating to aspects your caseworkers are struggling with)	• Pre-session reflection: Ask participants to reflect on the coaching sessions, and any topics	• Coaching feedback/ evaluation form	• GBV AoR Helpdesk, Tip Sheet: Collective Care (English): • GBV AoR Helpdesk,

	• CCS training package (re-read key modules relating to aspects your caseworkers are struggling with)	they would like to revisit or review, submit these requests to supervisor in advance to provide adequate time to prepare.		Annotated Bibliography: Collective Care Processes and Practices (English): • SVRI *Dare to Care Wellness Course*

SESSION INSIGHTS/ EVALUATION FORM

Session Number/ Title	
Date	
Name	

Your feedback helps strengthen the coaching sessions and improve support for caseworkers and child survivors. Participation is voluntary. Responses will be reviewed by supervisors/facilitators to improve future sessions.

1. KEY LEARNING

What is **one key message, skill, or insight** you are taking away from this session?

2. PRACTICAL RELEVANCE

How useful was this session for your **day-to-day case work**?

☐ Very useful ☐ Useful ☐ Somewhat useful ☐ Not useful

Optional comment:

3. REFLECTION ON PRACTICE

Did this session help you **reflect on or strengthen your practice** (e.g. attitudes, communication, assessment, coordination)?

☐ Yes ☐ Somewhat ☐ No

If yes or somewhat, please share one example:

4. SESSION PROCESS AND SAFETY

Did the session feel **respectful, supportive, and safe for participation**?

☐ Yes ☐ Mostly ☐ No

Optional comment (e.g. facilitation, pacing, group discussion):

5. LOOKING AHEAD

Is there anything you would like **more support or clarity** on in future coaching sessions?

COACHING FEEDBACK FORM

Date	
Name	

This form invites you to reflect on your overall experience of the CCS coaching program. Your feedback will help improve future coaching and strengthen support for caseworkers and child survivors. Thank you for your time, commitment, and thoughtful reflection.

1. OVERALL TAKEAWAYS

What are the **most important takeaways** you are leaving with from the CCS coaching program?

2. IMPACT ON PRACTICE

In what ways has the coaching program **influenced or strengthened your CCS practice** (e.g. attitudes, communication, assessment, coordination, supervision)?

3. CONFIDENCE AND SUPPORT

As a result of this coaching program, how confident do you feel in applying CCS principles and tools in your work?

☐ Very confident ☐ More confident than before ☐ About the same ☐ Less confident

Optional comment:

4. COACHING APPROACH AND EXPERIENCE

What aspects of the coaching approach worked well for you (e.g. group discussions, roleplays, case studies, facilitation style)?

5. LOOKING AHEAD

What suggestions do you have to **improve future CCS coaching programs** or better support caseworkers?

ADDITIONAL RESOURCES / FURTHER OPTIONAL READING

This section contains additional resources, including further optional reading to increase supervisor and participants' understanding of CCS and CCS-related issues.

Contact Information for Global Sources of Technical and Coordination Support

- GBV AoR: https://gbvaor.net/
- GBV AoR Regional Emergency GBV Advisors: https://gbvaor.net/about-us#rega-team
- CP AoR: https://cpaor.net/
- GBV Community of Practice: https://gbvaor.net/support#community-of-practice

Key CCS Related Resources

- Caring for Child Survivors of Sexual Abuse Guidelines (Multiple languages): https://gbvresponders.org/response/caring-child-survivors/
- UNHCR Best Interests Procedure for Refugee and Asylum-seeking Children at Risk (online course): https://agora.unicef.org/course/info.php?id=46300
- UNHCR. (2021). Best Interests Procedure Guidelines: Assessing and Determining the Best Interests of the Child: https://www.refworld.org/policy/opguidance/unhcr/2021/en/122648

Case management

- Interagency guidelines for Child Protection case management (Multiple languages): https://resourcecentre.savethechildren.net/document/inter-agency-guidelines-case-management-and-child-protection/
- Interagency guidelines for GBV case management (Multiple languages): https://www.gbvims.com/gbv-case-management-guidelines/

Gender-Based Violence (GBV)

- GBV Pocket Guide: How to support survivors of gender-based violence when a GBV actor is not available in your area. (Multiple languages): https://gbvguidelines.org/en/pocketguide/
- Core competencies for GBV Coordinators and Specialists Documents (English): https://gbvaor.net/sites/default/files/2019-07/Core%20Competencies%20for%20GBV%20Specialists%20-%20GBV%20AoR%2C%202014.pdf

Information Management

- GBVIMS (Multiple languages): https://www.gbvims.com/

Preventing Sexual Exploitation and Abuse (PSEA)

- Safeguarding Resource and Support Hub (multiple languages): https://safeguardingsupporthub.org/

Sexual Reproductive Health and Rights (SRHR)

- IPPF Technical Brief on Comprehensive Sexuality Education for Adolescents in Humanitarian settings https://www.ippf.org/sites/default/files/2022-01/Technical%20brief%20-%20Comprehensive%20Sexuality%20Education%20for%20adolescents%20-%20English.pdf
- IPPF guide to advocating for Comprehensive Sexuality Education: https://www.ippf.org/resource/evidence-action-advocating-comprehensive-sexuality-education
- IPPF comprehensive sex education articles: https://www.ippf.org/our-approach/services/comprehensive-sex-education

Women and Girls Safe Spaces

- GBV AoR Helpdesk, Differences between one-stop centres (OSCs) and women and girls' safe spaces (WGSS). (Multiple languages): https://www.sddirect.org.uk/resource/understanding-core-functions-and-differences-between-women-and-girls-safe-spaces-and-one
- Laaha - a safe space for women and girls online: https://laaha.org/en/home

Self and Collective Care

- GBV AoR Helpdesk, Tip Sheet: Collective Care (English): https://www.sddirect.org.uk/sites/default/files/2024-02/GBV%20AoR%20HD%2024%20-%20Collective%20Care%20Tip%20Sheet.pdf
- GBV AoR Helpdesk, Annotated Bibliography: Collective Care Processes and Practices (English): https://sddirect.org.uk/sites/default/files/2024-03/GBV%20AoR%20HD%202024%20-%20Collective%20care%20annotated%20bibliography%20final.pdf
- SVRI *Dare to Care Wellness Course*

Other

- Rosa phone app for continuous GBV learning: https://gbvresponders.org/rosa-skill-building-application-2/
- Coordination framework for CP and GBV: https://gbvaor.net/sites/default/files/2022-01/Gender%20Based%20Violence%20And%20Child%20Protection%20Framework_EN_FINAL.pdf
- Tip sheet for CP and GBV collaboration: https://cpaor.net/sites/default/files/2020-11/Tips%20for%20CP%20and%20GBV%20collaboration%20and%20coordination%20FINAL%20201028%203.pdf