INTERNATIONAL RESCUE COMMITTEE

CARING FOR CHILD SURVIVORS TRAINING

Gender Based Violence: Children as Survivors

Myths and Attitudes

1. Sexually assaulted women are responsible for the incident if they were not dressed properly in cultures that they know to be conservative
2. Female survivors of sexual violence suffer far greater than male survivors of sexual violence
3. GBV is part of certain cultures and so should not be challenged as this would challenge accepted cultural values
4. A GBV survivor should always report his/her case to justice authorities.

Gender Vs Sex

Sex relates to the reproductive biological characteristics of women and men

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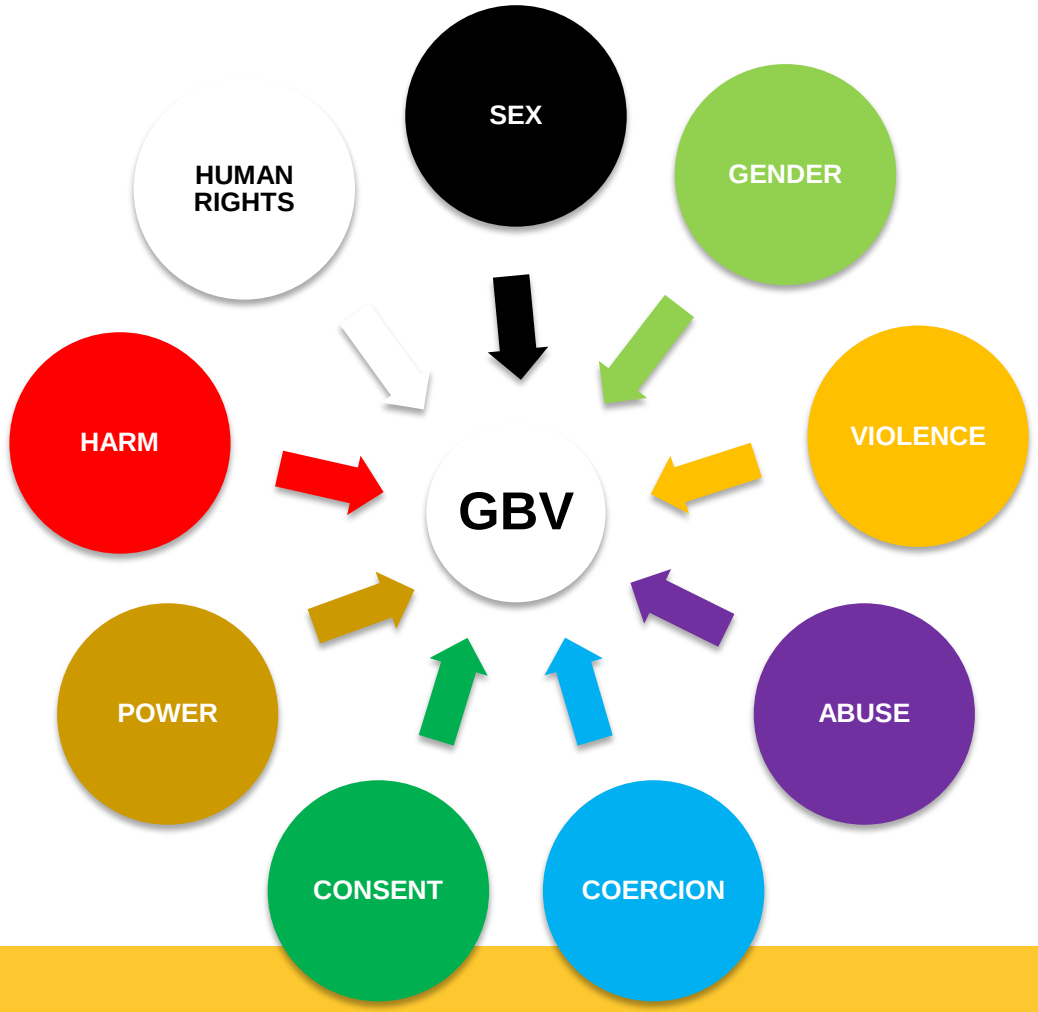
Gender refers to social characteristics (roles, responsibilities, tasks, behaviors) which are attributed according to the sex of the person

What is gender based violence?

Gender based violence is an umbrella term for any harmful act that is perpetrated against a person's will, and that is based on socially ascribed (gender) differences between males and females.

Inter-Agency Standing Committee Guidelines on GBV interventions in Emergencies

GBV Key Concepts



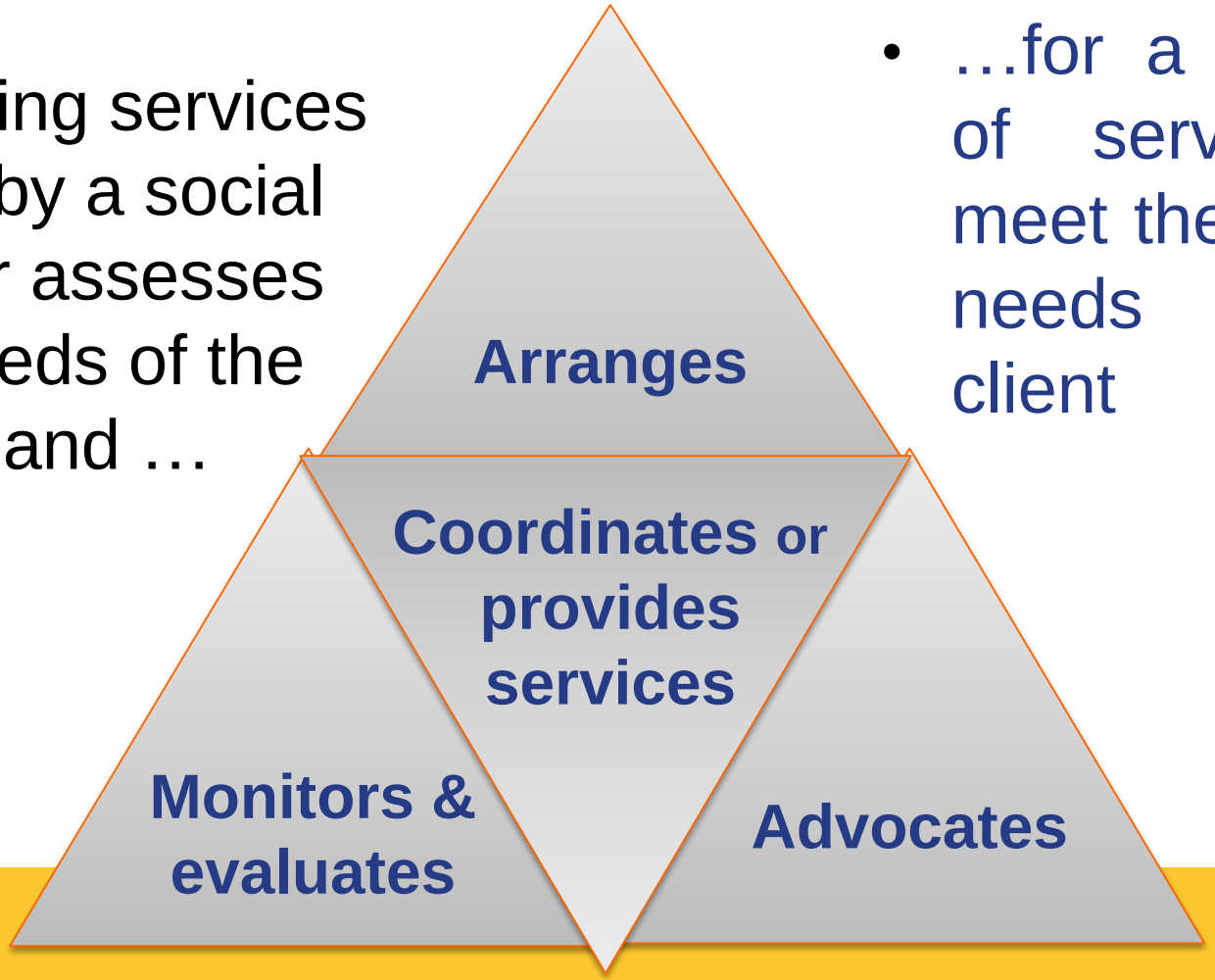
Categorizing GBV

- **Physical Violence**
- **Emotional Violence**
- **Economic Violence**
- **Sexual Violence**
- **Harmful Traditional Practices**

Introduction to Child Survivor Centered Case Management

Case management

* Providing services whereby a social worker assesses the needs of the client, and …



- …for a package of services to meet the specific needs of the client

Caseworkers must have in-depth knowledge of the services agencies can provide, including:

- for medical care,
- safety assistance,
- legal counseling and assistance,
- and psychosocial services…

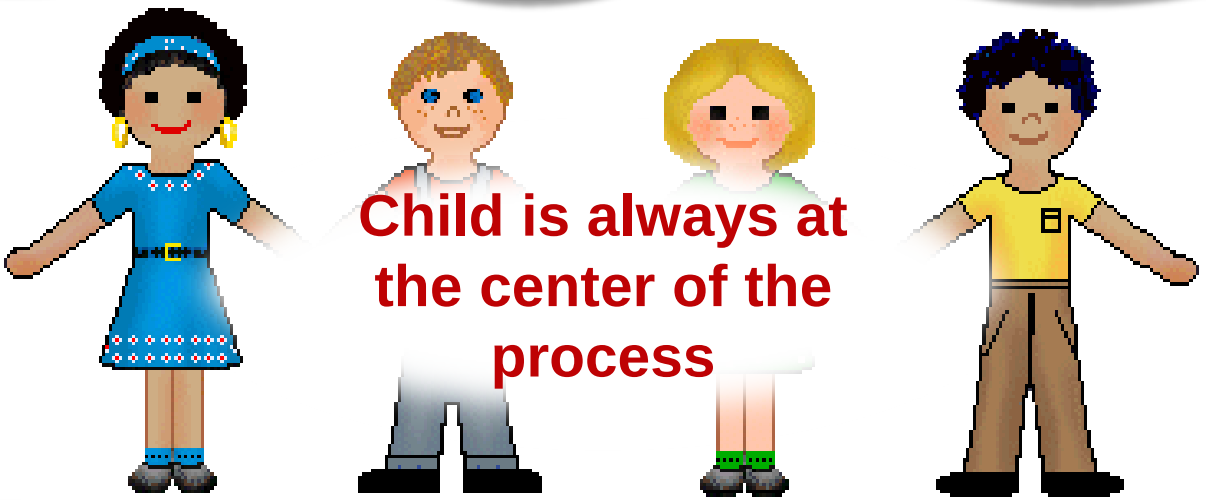
And share this information with the child / carers, in order to **empower** children and help caregivers make **informed choices** in their best interest. This is part of informed consent process

Child centered case management – influencing factors

Perpetrator

Type of abuse

Child's situation



Child is always at the center of the process

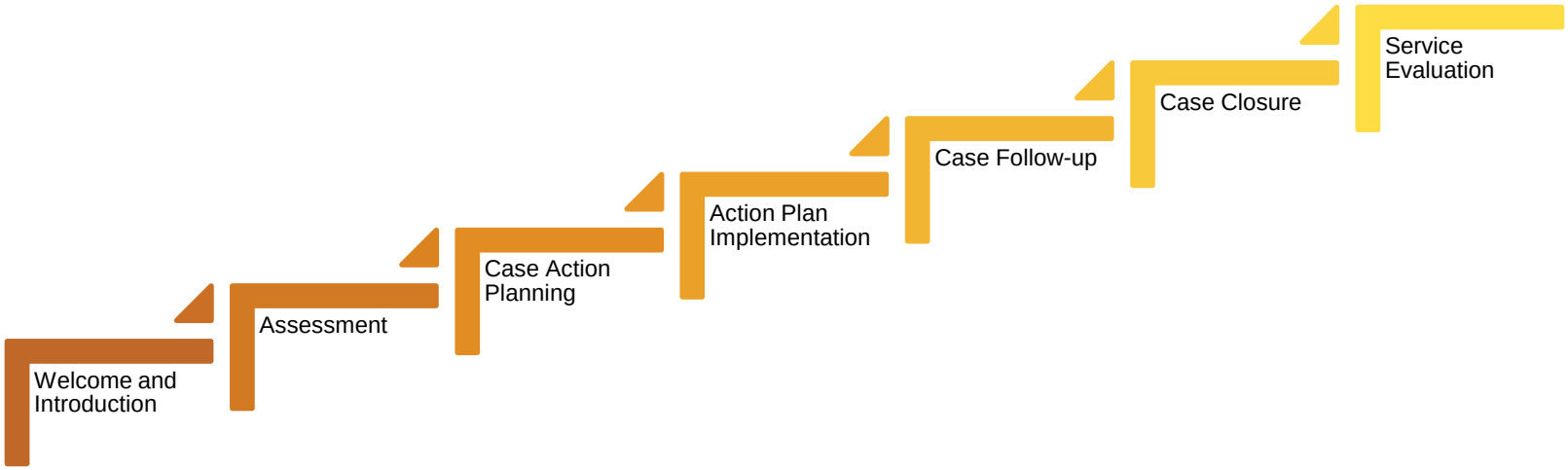
Age & development stage

Family dynamics

Context & resources available

Case management Process & Steps

7 steps of child-centered case management



Intake & assessment	• Interviewing / communicating with child survivors • Sharing information in way can be understood • Informed consent, confidentiality procedures & best interest of child • Addressing mandatory reporting
Develop action plan	• Balancing decision making roles • Informed consent and referrals
Implement the plan	• Advocacy & accompaniment of child survivors • Involving caregivers/family in care & treatment help • Direct interventions provided (psychosocial support)

Implement the plan	• Referral • Coordinating with other service providers
Follow-up & review	• Re-assessment of safety and risk with child survivors • Advocacy on behalf of child clients • On going case coordination and review
Case closure	• Criteria for when and how a case with child be closed

Overall key differences

- Balancing confidentiality & best interests of the child
- Involving parents / caregivers
- Nature of support needed and to be given – esp. with regards to care arrangements, and form of PSS
- Adaptation to age & stage of development
  - Communication methods
  - Level of involvement of child in decision-making

At each stage ask ourselves:

- What are the risks to the child's safety?
- What will achieve the 'best interests of the child'?
- At what level can the child participate at this stage?
- Who else (other than child) should be consulted?
- What decisions have been taken and why?
- What resources can be used to assist the child?
  - What is your organization's plan for intervention? Is this within your organization's project objective?
  - What other organizations have suitable resources/ support?
- What is the timeline for action?

Roles and Responsibilities

Core responsibilities of the Caseworker

The primary duties of the caseworker are to:

1) Establish rapport & develop trusting relationship to help child & family,
2) Support & advocate on behalf of child & family,
3) Act as the child's & family's point of contact for assessment of needs,

Core responsibilities II

4) Develop goals & planning interventions, and
5) Provide, coordinate & follow-up on provision of services

- Actions underpinning these responsibilities:
  - Information sharing as it helps to empower child & family
  - Ensuring child & caregivers stay at center of the process

When lead case management agency

- When designated lead case management agency, additional responsibilities include:
- Handling mandatory reporting requirements,
- Organizing case conferencing meetings, and
- Conducting other tasks required in the case management process.

Core responsibilities: Case Supervisors

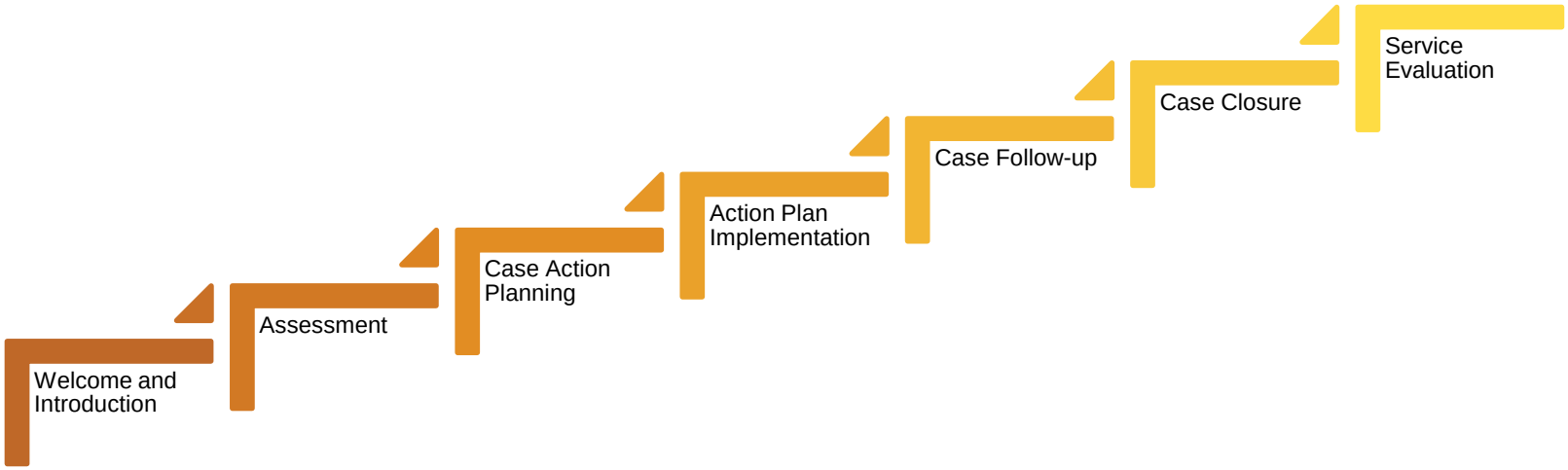
Provide support, advice, direction

- Case supervisors are on-hand for consultation in emergency situations
- Provide regular case supervision to caseworkers

- Ensure overall quality oversight to the caseworker
  - Ensure staff trained & prepared for case management role & responsibilities
  - Work closely with other senior staff to oversee quality of service for children & families

Step 1: Introduction & engagement

7 steps of child-centered case management



Key terms

Informed consent: voluntary agreement of an individual who has the legal capacity to give consent

Informed assent: expressed willingness to participate in services

i. Greet & comfort the child

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Intro & engagement starts first time meet with child survivor and / or child's caregiver

- Develop rapport, build trusting relationship

- Begin to asses:
  - Child's maturity, age & development
  - Caregiver's support to the child
- Start providing information
- Ask yourself: Is it safe for the child to speak in presence of caregiver?

ii. Obtain permission to proceed

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- By providing full explanation of the case management process and giving all the information relevant to the situation, the case worker can get full informed consent to proceed

Case worker should explain

- What case management is
- Individual roles & responsibilities within case management process
- Services available
- Benefits & limitations of services
- Regulations governing such services (e.g. confidentiality protocols)

- Meaning of confidentiality, & when it cannot be kept
- How client information is safely & securely stored
- Ways in which client information will be used

➢ **Always offer children & caregivers opportunity to ask questions or share concerns during this discussion**

When to seek consent

- At the start of case management services
- As part of case management
- During case referrals
- Obtain permission to proceed when you have explained all the above

Obtaining informed consent/assent

ACTIVITY

Break into 4 groups
Each group assigned an age group:
- 0–5, 6–11, 12–14, 15–17

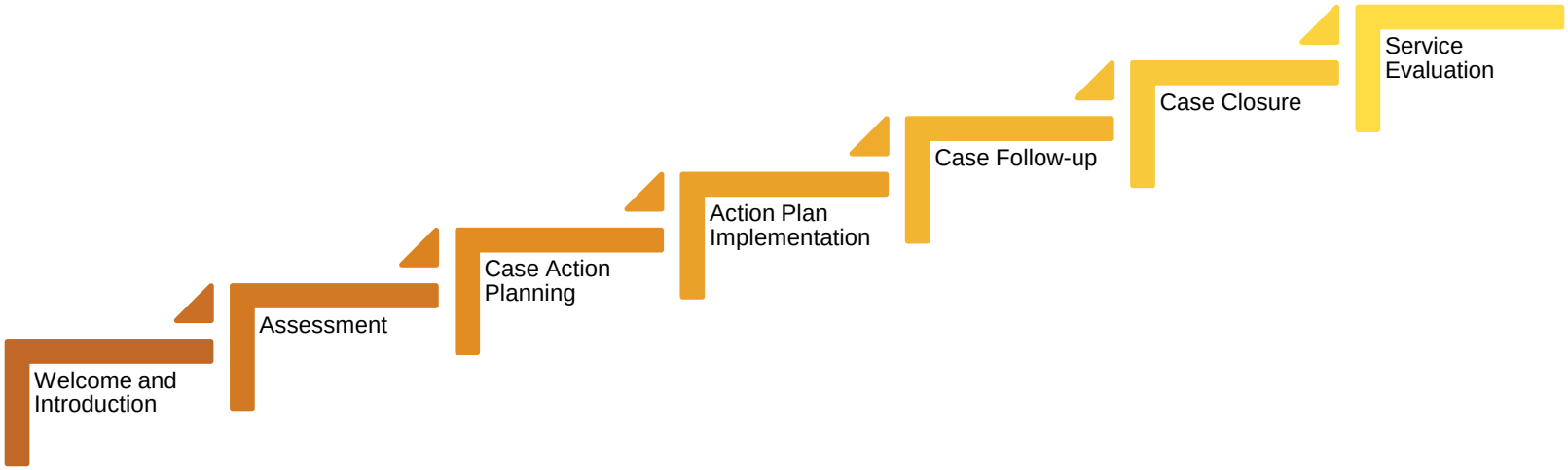
Answer the following questions:
- Who provides informed consent, adult or child?
- Do you need child's informed assent?

- 10 mins
- 3 mins each group to present

AGE GROUP	CHILD	CARE GIVER	IF NO CAREGIVER or NOT IN CHILD's BEST INTEREST	MEANS
0 – 5	–	Informed consent	Other trusted adult's or caseworker's informed consent	Written consent
6 - 11	Informed assent	Informed consent	Other trusted adult's or case worker's informed consent	Oral assent, Written consent
12 - 14	Informed assent	Informed consent	Other trusted adult's or child's informed assent. Sufficient level of maturity (of child) can take due weight	Written assent, Written consent
15 – 17	Informed consent	Obtain informed consent with child's permission	Child's informed consent & sufficient level of maturity takes due weight	Written consent

Step 2: Intake & assessment

7 steps of child-centered case management



i. Intake & assessment session

Before you begin to talk directly with the child:

- If child was referred to the caseworker by another service provider, the option of gathering information from those already involved in child's case should be explored.
- Also gather information from trusted adults (such as the parent)
- Remember communication techniques with others involved, not only the survivor.

Session Subjects

- Developing a context for the child
- Understanding what happened (nature, & timing of sexual abuse)
- Understanding who perpetrated the abuse & their access to the child
- Identifying if the child has already received care & services
- Other relevant information

ii. Assessment of care & treatment needs

Four broad areas of assessment

a. Child safety assessment
b. Child health needs assessment
c. Child psychosocial needs assessment – includes risk assessment for suicide
d. Legal / justice needs & action plan

- Based on consequences of abuse

a) Child safety assessment

- Determining child's safety is the **most important** priority assessment area
- Ask about child's safety concerns privately

Ask:

- Child's sense of personal safety at home
- Sense of safety in community
- Child's identified safety / support systems

Safety & protection - Protective intervention

- Collaborate with family & child to assess child's ongoing situation to establish practice, behaviors or situations needing to change in order for child to be safe and well
- Jointly agree what actions are needed to ensure child's protection
- When family poses risk or does not have capacity to ensure wellbeing external intervention may be necessary

b) Child health needs assessment

Possible health concerns include:

- Pregnancy
- Sexually transmitted infections, including HIV,
- Injury
- Infertility

Time critical medical care

- Prevention of HIV - post-exposure prophylaxis within 3 days (72 hours)
- Prevention of unwanted pregnancy – emergency contraception within 5 day (120 hours)
- Medical stabilization / treatment for injury or pain – variable but ASAP
- Evidence collection – within 48 hours

c) Child PSS needs assessment

- Possible indicators of distress:
- Child’s emotional state
- His/ her facial expressions
- Body language
- Other behavior
- Reported behavioral change (ask caregivers)

PSS Assessment process

- Explain why you are asking these questions
- Ask about any changes in the child's activities – school attendance, leaving the house, playing with friends, etc.
- Ask about child's feelings
- Ask about changes in sleeping, eating or hygiene habits

➢ **These all indicate if there are symptoms of distress as explained in session on Knowledge Areas – Impact of Sexual Abuse**

Identify coping strategies

Identify The Child's Strengths, Strengthening Belief Systems and Features of a Supportive Environment

d) Legal / justice needs

Primarily you must determine the child and caregiver's interest in pursuing legal action through the available justice system

Inform client about options – both formal and informal justice mechanisms and pros/cons of both

Refer to legal aid center if one exists

Remember: Our role

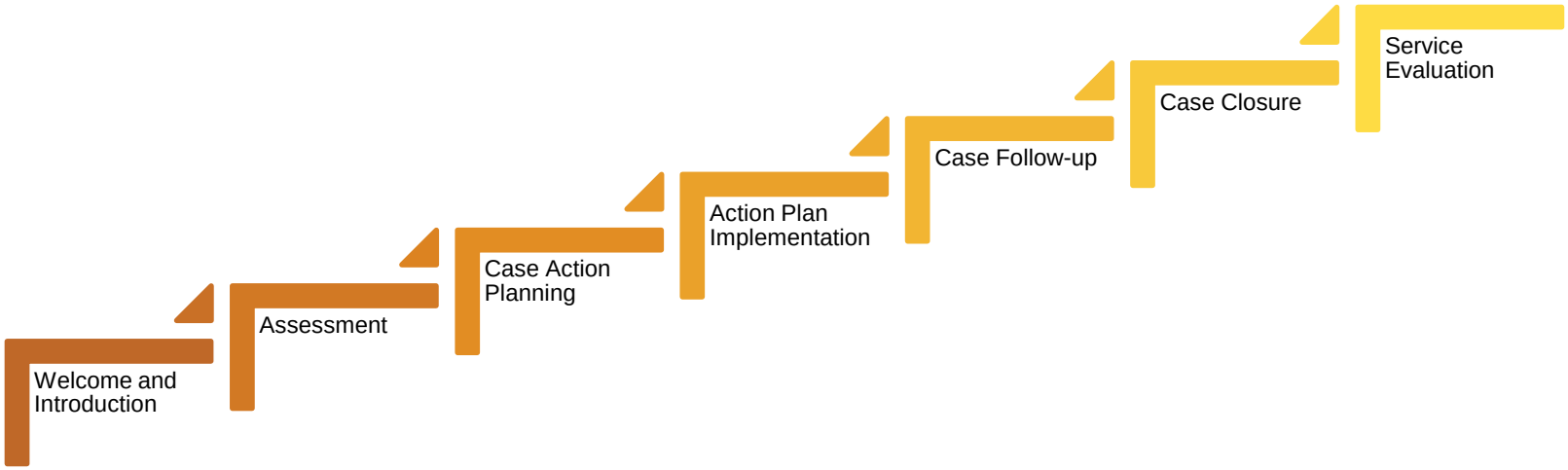
- We must work to ensure safety
- We work to ensure healing
  - Ensure access to psychosocial support & health services
- We assist if seek legal / justice support
  - This feeds into our action plan – what we will do, who we will refer to

Remember: Key points

- Need safe, supportive & caring environment during intake & assessment interview
- Assessment information – on strengths & needs - is gathered to make an action plan. Assessment of the child's needs should be on-going
- Safety & medical assessment take priority over PSS and legal/justice assessment. (Unless there is indication of suicidal thought)

Step 3: Case action planning

7 steps of child-centered case management



i. Develop the case action plan

- In conjunction with intake & assessment step
- In partnership with child & his/her caregivers – their views influence decisions
- Before child leaves case worker's office
- Based on wishes & main needs or child and / or caregivers

➢ **Decide WHO will do WHAT, by WHEN**

Case action plan comprises referral or direct service provision of the following four types:

a) Safety & protection from further abuse / protective intervention
b) Clinical health care and treatment
c) Psychosocial support
d) Access to justice

a) Action planning for safety

Safety action plan includes:

- Referral to protection & security agencies
- Individual safety plan, that may include e.g.:
  - Referral to protection / security agencies who may tighten security in an area
  - Making sure child does not walk / go out alone
  - Practice how child will react to seeing / coming into contact with perpetrator
  - Fostering (if threat is within the home)

b) Action planning for medical care

Need to document:

- Whether a medical referral has been made. If not why not
- If the child needs accompaniment
- Who will accompany the child

c) Psychosocial support action planning

Core interventions:

- Provide emotional support
- Provide basic education about sexual abuse
- Assist the child with specific problems
- Provide counseling to caregiver / family
- Crisis intervention for children with suicidal thoughts

ii. Obtain informed consent /assent for referrals

- Provide child / caregiver full & complete information about options for medical care, safety assistance, legal support, & psychosocial services
- Explain what is going to happen – benefits & risks
- Decide together what information will be shared
- Make accompaniment plans for referrals

iii. Review case action plan

- Once gone through each assessment need & developed action plan, conduct final review of documented plan with child client /caregiver
- Caseworker should also schedule a follow-up meeting with the child and caregiver

1st: Ensure safety

2nd: Referral for medical support

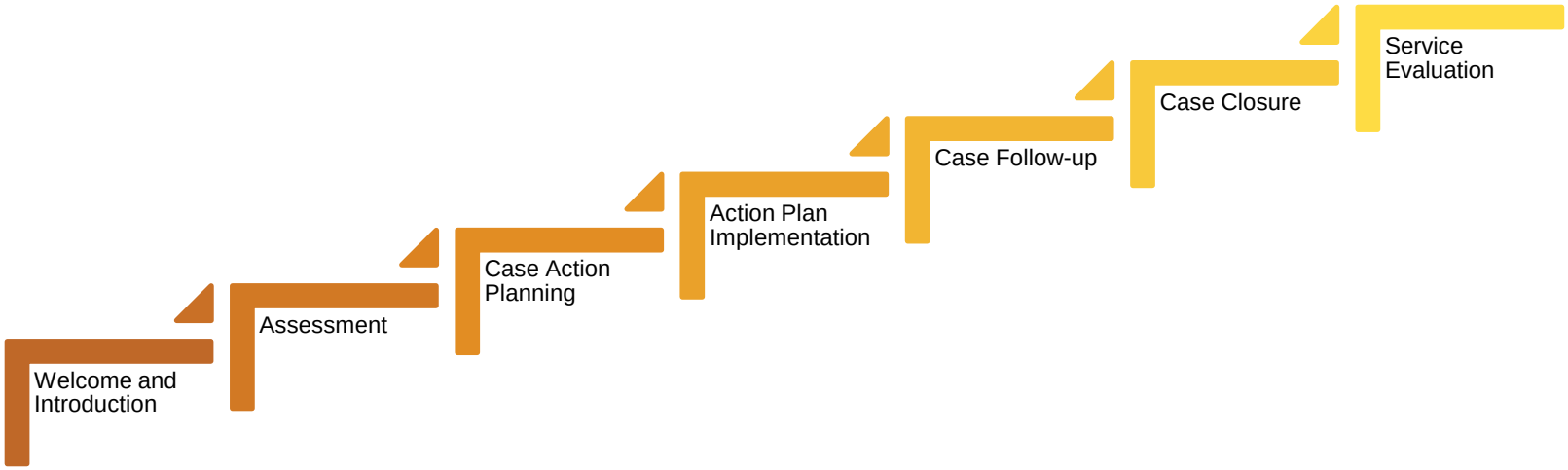
3rd: Psychosocial support – direct or indirect provision

4th: Legal / justice support

Decision makers: child, care-givers present, and adults known and trusted by the child, case worker, possibly case supervisor.

Step 4: Implement plan

7 steps of child-centered case management



i. Assist & advocate for child to obtain services

- Accompanying children / caregivers to police, health & other service providers
- Advocate on behalf of child
  - For police & security to take protective measures
  - For compassionate & quality medical care & treatment
  - For child's views to be taken into consideration
- Meeting with service providers to explain what happened (where appropriate), and provide information on abuse

ii. Provide direct service interventions – psychosocial

- Direct psychosocial interventions: provided by caseworker directly to child &/or family. E.g.:
- One-on-one sessions with child client
- Family meetings to discuss specific problems or issues happening in family because of sexual abuse
- Sharing with child ideas for reducing stress & anxiety
- Other interventions your program offers

iii. Complete mandatory reporting procedures

- Based on the requirements in the local setting, caseworkers or supervisors are responsible for completing the necessary reports
- The child and caregiver must be fully aware of the process, procedures and protocol

iv. Coordination & Case Conferencing

- Case conferences often when child's needs not being met in timely / suitable way. Opportunity to:
  - Review activities, progress & barriers towards goals;
  - Map roles & responsibilities;
  - Resolve conflicts or strategize solutions; &
  - Adjust current service plans
- Can help ensure more holistic, coordinated & integrated services across providers; & reduce duplication

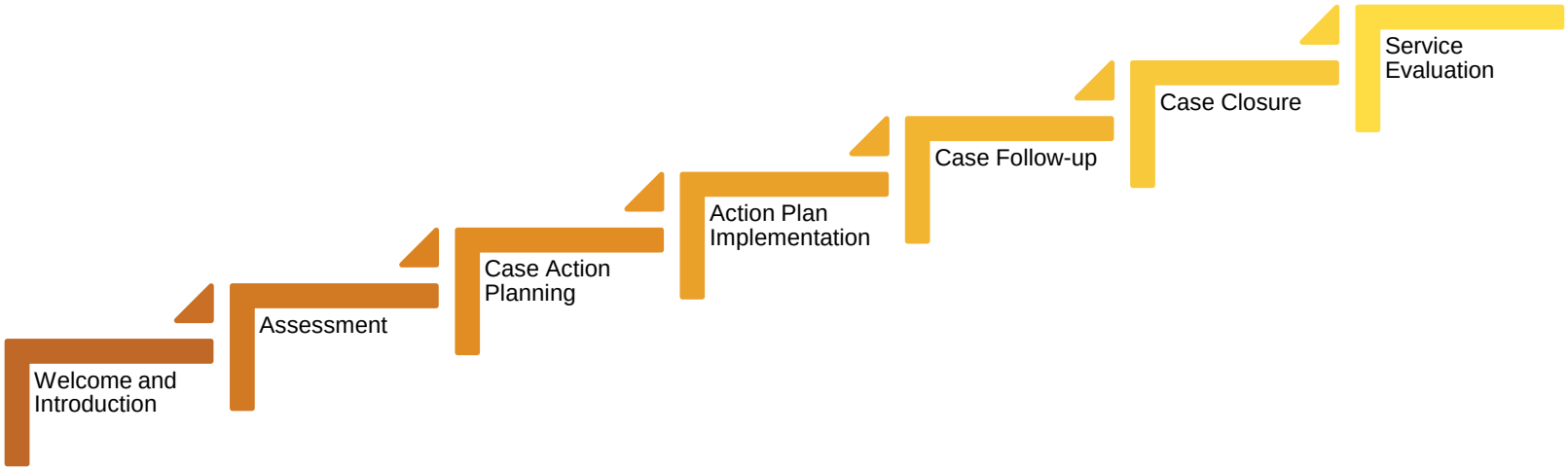
Additional Activities

Where possible complement essential safety, health, legal and PSS actions with :

- Empowerment activities with girls and boys – life skills building
- Economic strengthening
- Behavioral change & awareness raising with the community as a whole
    - Including in relation to gendered assumptions and GBV.

Step 5: Case Follow-Up

7 steps of child-centered case management



Case Follow-up & Monitoring progress

- Purpose of the case follow-up visit:
  - Ensure child has received needed services
  - Assess any improvement in the child's situation
  - Re-assess the child's safety
  - May revisit the access-to-justice
- **This is a "final assessment" of any outstanding needs**

Follow-up Process

Times & mechanisms for case follow-up with child & caregiver during Step 2 & 3

- Follow-up meetings should take place in a location where the child is comfortable and confidentiality can be protected
- Follow-up visits should have a specific time, date & place based on individual needs

Final assessment / revised plan

If certain needs are not met (‘N’ for ‘no’ marked against any answers in Final Assessment section of the form):

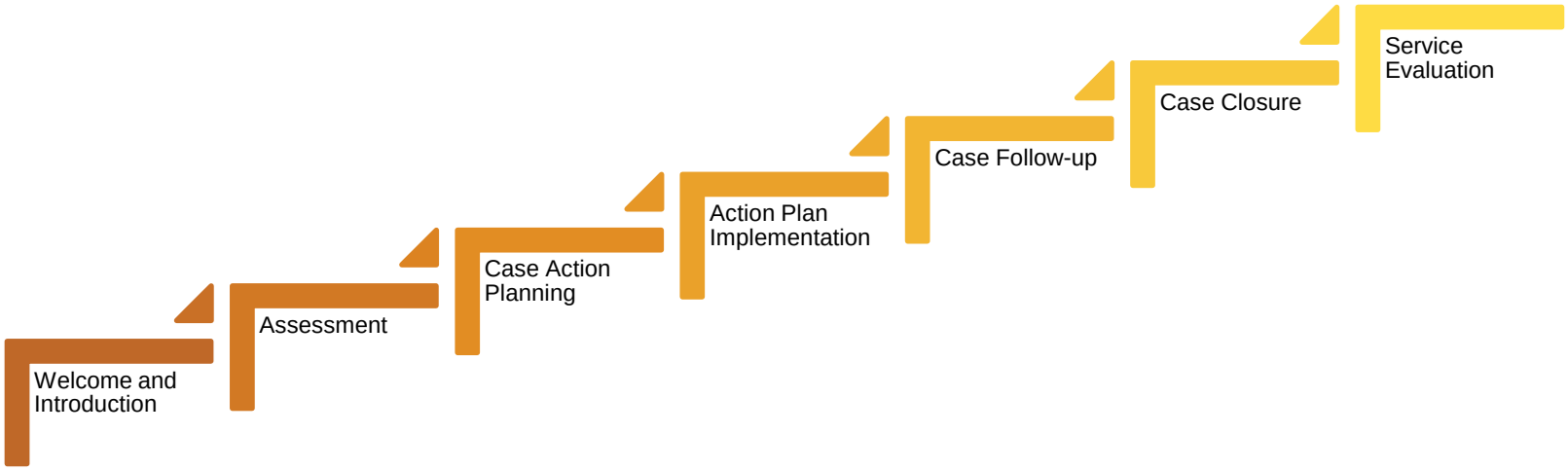
Casework with child/caregiver take steps to:

- Develop revised action plan
- Refer to further services – i.e. implement the revised plan

- Another follow-up visit to be scheduled until all needs met

Step 6: Case closure

7 steps of child-centered case management



Discussion questions

In your context:

When should a case get closed?

When to close a case

- Case plan completed, follow-up finished
  - Child and family's needs are met
  - Normal & new support systems are functioning
  - Child centered: child & caseworker agree no further support needed
- No client contact for specified period
- Hand over of case to another agency
- Death of child / child leaves location

Discussion questions

In your context:

- What are current case closure criteria in this context?
- What are the challenges in taking the case closure step?

Steps in case closure

- Complete a satisfactory follow-up meeting
- Discuss with child & caregiver possibility of closure
- Agree closure
- Remind child (& caregiver) they can contact caseworker in future
- Document when case closed
- Retain case files

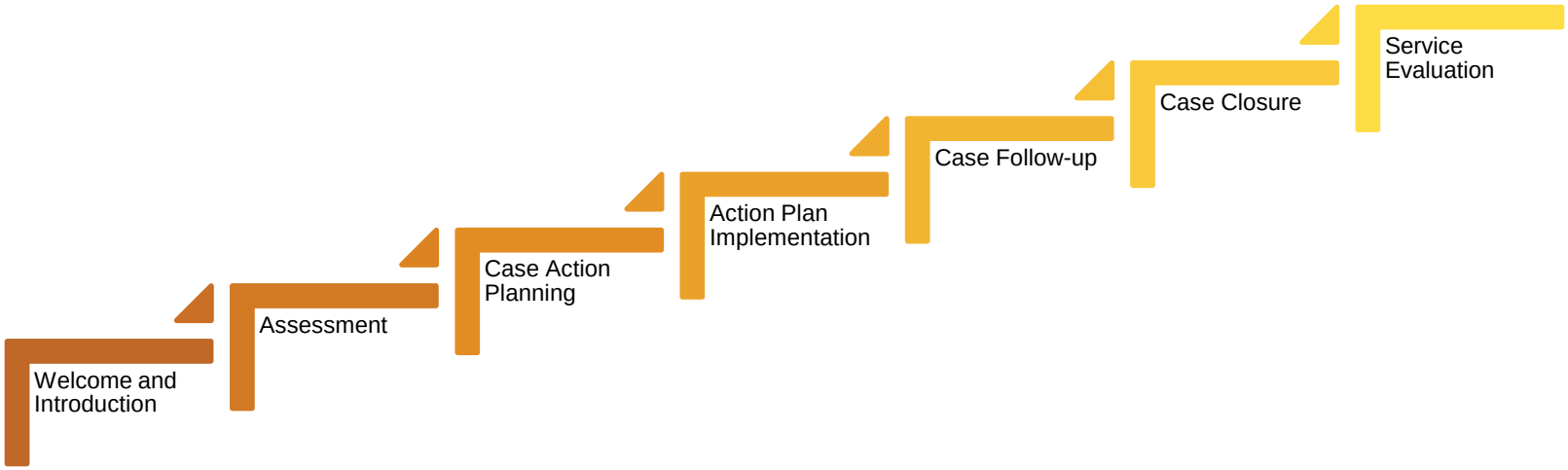
When It Is Only Possible to See the Survivor Once

What should you do?

- Prioritize assessment & case action planning
- Provide as much info as possible to child & carers
  - Possibly deliver some Psycho- Social support
- Thoroughly document information provided
- Keep case open 30 days
- Close case if no contact with child after 30 days

Step 7: Service evaluation

7 steps of child-centered case management



Service evaluation - purpose

- Evaluation provides feedback to caseworkers & agencies on services & support received by clients
- Purpose to improve services & better meet needs of clients
- Can evaluate service provision or individual staff competencies

Service evaluation methods

- To evaluate service provision: client satisfaction questionnaire, and/or
- To evaluate individual staff competencies: Supervisor carry out:
  - Final case review / case management skills assessment
  - Checklist

➢ Most appropriate method depends on context

i. **Client satisfaction questionnaire**

- Optional tool, can be used in more stable settings
- Aim is to evaluate services not to evaluate individual staff members

How:

- Interview with child survivor and his / her caregiver

Who:

- Someone other than the direct case worker
- If survivor able to read / write - can complete form on his / her own

SESSION TWO: PSYCHOSOCIAL INTERVENTIONS & TRAUMA

Psychosocial assessment & interventions for child survivors

Advanced Case Management

Standard Case Management

- Intro, Engagement, Intake & Assessment
- Case Action Planning
- Implement the Action Plan
- Case follow up/Monitoring
- Case Closure
- Evaluation of Service

Advanced Case Management

- Intro, Engagement, Intake & Assessment
- Case Action Planning
- Implement the Action Plan
- Psychosocial Interventions
- Case follow up/Monitoring
- Case Closure
- Evaluation of Service

Aims of PS interventions

Provided to help child survivors (& family members) to:

1. Understand & manage reactions to abuse
2. Develop skills for managing anxiety & stress
3. Learn new skills for coping with negative reactions, &
4. Acquire new problem solving skills

The when & what

WHEN: After child's immediate health & safety needs met. Likely during "implement actions" step

WHAT: Evaluate broader areas & needs of child, family & community. Any additional info. on abuse

The who & how

WHO: Gather information from the child when aged 8+ years, non-offending caregivers and other trusted sources close to the child as decided by child and caseworker

HOW: Develop a strategy, thinking through number of interviews, techniques and tools to be used

Psychosocial interventions for child survivors

The following psychosocial interventions can be applied in cases of child sexual abuse:

① Providing Healing Education

② Relaxation Training

③ Coping Skills

④ Problem Solving

Healing education & relaxation training can be helpful even if child does not express psychosocial difficulties following sexual abuse

① Providing Healing Education

Type of education aimed at increasing child and family's understanding of what happened

Improves children & families' ability to cope with the experience by:

A. Provide children & caregivers with understanding of sexual abuse & associated impacts
B. Ensure children & caregivers can identify signs & symptoms of trauma

② Relaxation training

Children experience anxiety and / or psychosomatic complaints resulting from anxiety & stress

Relaxation techniques help children feel in control of their bodies & calm their minds. This intervention aims to:

A. Ensure that children & caregivers sleep & eat regularly
B. Ensure that children & caregivers manage stress-related symptoms on their own

③ Coping skills

Children may have negative feelings after sexual abuse. Coping skills help children learn to help themselves. This intervention aims to:

A. Help children recognize their feelings, positive and negative
B. Help children increase their capacity to cope with difficult emotions

④ Problem solving

Children have ideas & knowledge about how to solve their problems. Caseworkers can help children develop “problem solving plans” to address their main problems. This intervention aims to:

A. Teach children and caregivers to identify everyday problems

B. Empower children and caregivers to think through solutions

Key points

- 4 psychosocial interventions described and demonstrated can be used as a starting point to help children recover
- Child survivors with more extreme and persistent signs of distress should be referred to specialized mental health services whenever and wherever they are available

An Introduction to GBV & Trauma

Trauma: An Introduction

‘Trauma’ means wound. In both medicine and psychology, it refers to major physical or mental injuries, including threats to life or physical integrity.

A ‘traumatic event’ is one that has the capacity to cause mental or physical trauma.

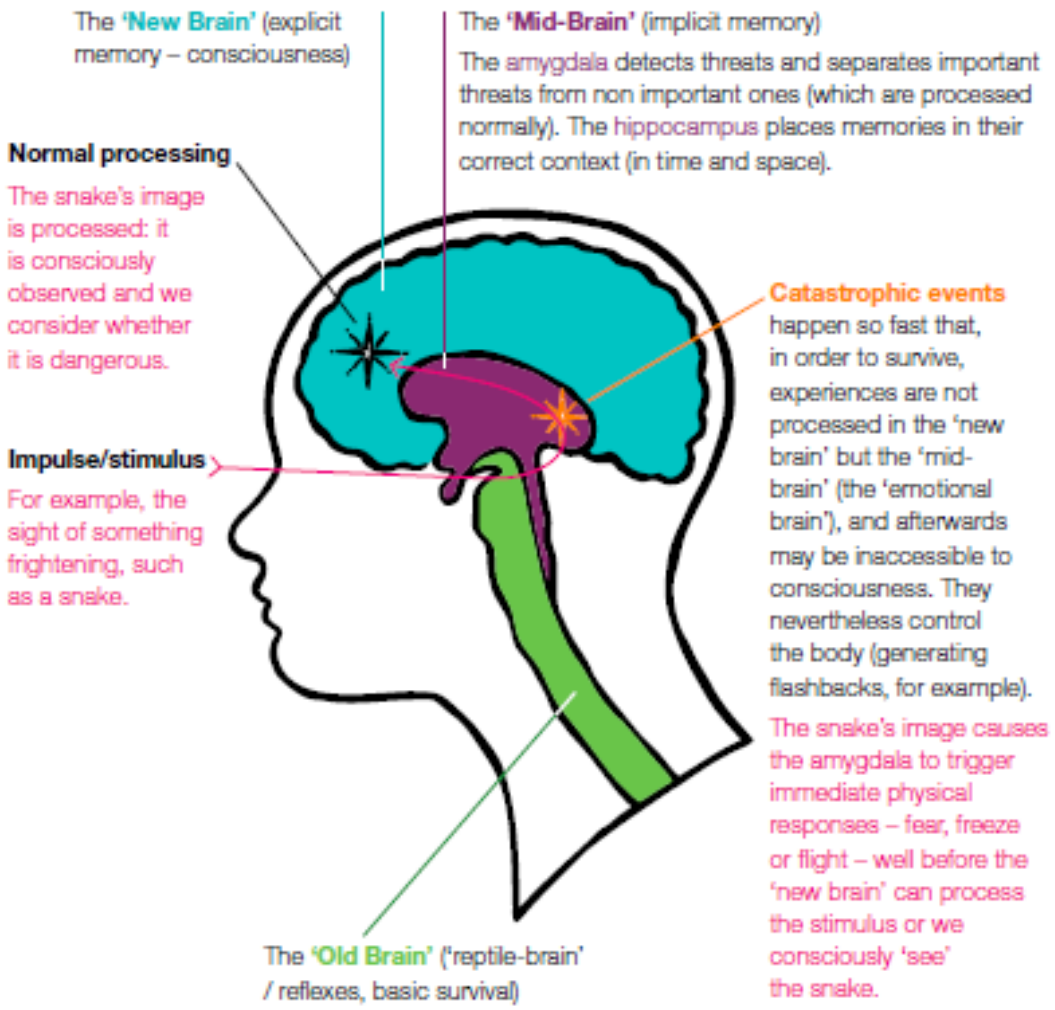
- Faced by such an event, the immediate response of the body and the mind is to struggle for survival.
- Behaviourally this is expressed by ‘fight, flight or freeze’ responses, submission or ‘playing dead’.

A severe traumatic event often changes the way in which survivors understand the world around them.

- Sense of safety
- Trust in other people
- Personal encounters with human or man-made violence

Biological Mechanisms

- The main reactions or survival ‘strategies’ that human beings display when faced with life-threatening events are:
  - Fight.
  - Flight.
  - Freeze.
  - ‘Playing dead’/submission.
  - When a traumatic event occurs that threatens life, we cease to process events in the usual way.
- We no longer store our emotions, feelings, and perceptions of the situation in the cerebrum, as we usually do, but process them at a ‘deeper’ level.
- This can produce the ‘primitive’ defence responses mentioned above.


The 'New Brain' (explicit memory – consciousness)
The 'Mid-Brain' (implicit memory)
The amygdala detects threats and separates important threats from non important ones (which are processed normally). The hippocampus places memories in their correct context (in time and space).
Normal processing
The snake's image is processed: it is consciously observed and we consider whether it is dangerous.
Impulse/stimulus
For example, the sight of something frightening, such as a snake.
Catastrophic events happen so fast that, in order to survive, experiences are not processed in the 'new brain' but the 'mid-brain' (the 'emotional brain'), and afterwards may be inaccessible to consciousness. They nevertheless control the body (generating flashbacks, for example).
The snake's image causes the amygdala to trigger immediate physical responses – fear, freeze or flight – well before the 'new brain' can process the stimulus or we consciously 'see' the snake.
The 'Old Brain' ('reptile-brain' / reflexes, basic survival)

Conducting Interviews with GBV Survivors

- Identifying Triggers
- Non-Linear Memory and Trauma
- Safety & Security
  - Consider the environment
  - Location for Interview
    - Security Assessment
- Giving maximum control to the survivor

Re-Telling the Story and Trauma

- A trigger wakens the memory of trauma. As a spark lights a flame, a trigger wakens the trauma.
  - In trauma work we make a lot of effort to understand and disempower triggers.
- Trauma-memory is unlike ordinary memory. It is linked to our senses, emotions and movement, so experience of trauma memories is very alive.
- Mostly, trauma-memory is body-memory. This means that we experience it as reactions in the body, while the content and order of the original event may be fragmented and partly forgotten.

Calming a Survivor Who Has Been Triggered

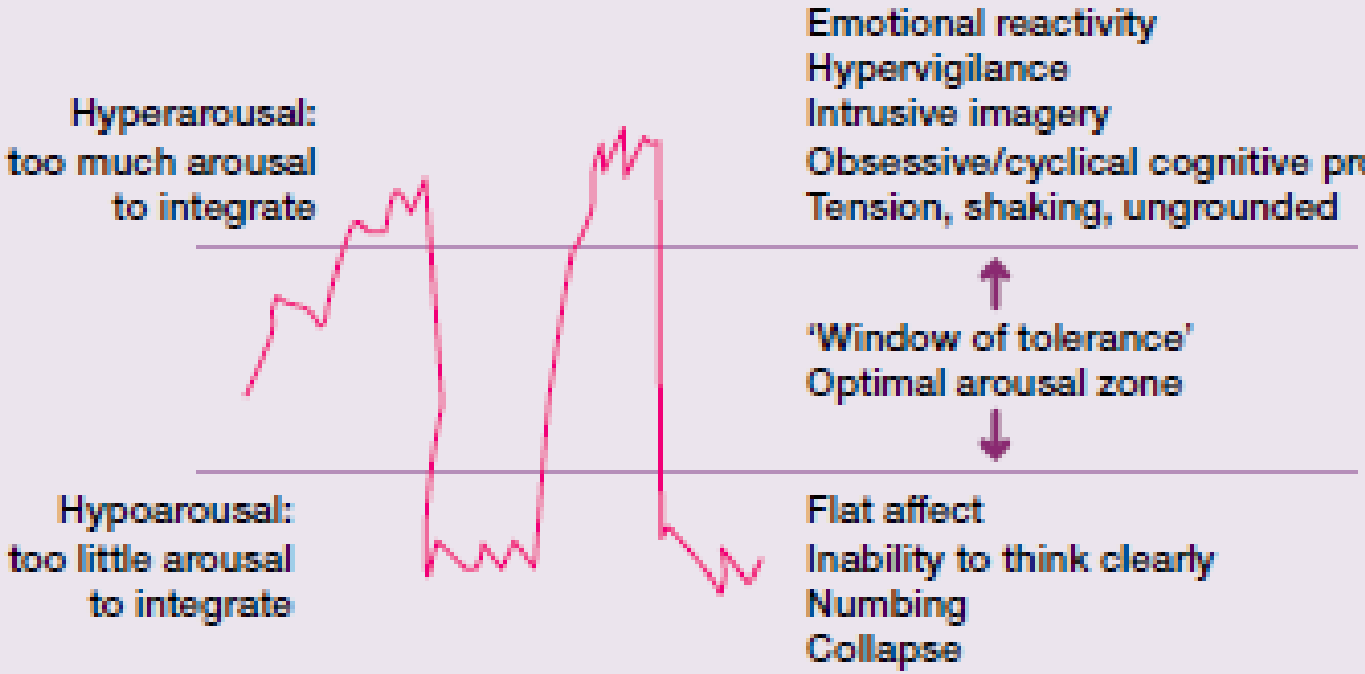
- You are in the office (or where you are at the present moment) now.
- You are safe here in this room.
- You are here now and not where the traumatic event happened.
- You are strong and courageous.
- Remember to breathe.
- Look around, try to be present here and now.

You might give the survivor a stone, or something else, to hold in her hand to keep him/ her grounded.

Window of Tolerance

A survivor is *dysregulated* when her emotional responses are poorly regulated; her emotional
state is labile and she has mood swings. This often occurs when a person is overwhelmed (hyperactivated) or very low (hypo-activated), or swings between both states.

The 'window of tolerance': maintaining optimal arousal



Adapted from Ogden and Minton 2000, at www.sciencedirect.com.

Grounding/ Stablisation Exercise
Re-orienting to the present (10 minutes.)

Look around and name 3 things you see.

Look at something (an object, a colour, etc.).

- Tell yourself what you are seeing.

Name 3 things you hear. If it feels comfortable, you can close your eyes.

Listen to a sound (music, voices, other sounds).

- Tell yourself what you are hearing.

Name 3 things you touch.

Touch something (different textures, different objects).

- Tell yourself what you are touching.

Now, notice your state of mind.

- Do you feel that you are more present in the room after doing the exercise, or less present?
- Do you feel calmer or more energised?

When you finish the exercise, take time to note how you feel. At the end, remember to come out of your role. Brush away the role you have played and say aloud “I am [me]”.


Memories of the past
Good experiences now
Safe places to rest
Plans for the future
Learn new skills
Dreams and longings
...to save money
...to educate children.
The family together.
The choices we have.
Strong enough
Grateful
Safety. Solid ground.

Self- Care and Trauma

Vicarious trauma

Vicarious trauma, also called **secondary trauma** or **indirect traumatization**, is a process of change that happens when the worker begin to identify with the clients she/he is working that results in changes in the worker's thoughts, feelings, and behaviors that are:

- Parallel to those of trauma survivors
- Generated from the experiences of clients
- Transmitted from clients to workers

Over time, this can cause changes in your physical, psychological, emotional, and spiritual well-being.

It can lead to very high, and possibly unrealistic, expectations of yourself and others

Adapted from Headington Institute, 2008; Admira Foundation, 2005

Signs of vicarious trauma

Physical	Emotional	Behavioral	Cognitive
• Sleep disturbances	• Anxiety • Startle response • Denial or numbing • Depression • Reawakening of own past trauma	• Social withdrawal • Addiction (alcohol, drugs, gambling, etc.)	• Nightmares • Polarized thinking • Entrenched cynicism • Obsession with bad people or things

Concern Worldwide, 2012

Protective and risk factors

Protective Factors	• Social Support • Optimism and healthy self-esteem • Spirituality • Adaptability • Tendency to find meaning • Curiosity and openness to experience • Aptitude
Risk Factors	• Nature and intensity of past traumatic experiences • Nature and intensity of current triggering traumatic or stressful event • Number of stressors experienced • Length of exposure to stressful situations • Organizational factors • History of previous psychiatric illness • Lack of social support • Pronounced introversion • Negativity and pessimism

Headington Institute, 2008

Self-care Techniques

Physical	Emotional/Relational	Spiritual
Regular exercise	Nurturing relationships	Knowing your values/where you find meaning in life
Sleep	Contact with home/friends	Participating in a community of meaning and purpose
Healthy eating	Talking	Regular times of prayer, reading, meditation
Drinking water	Ongoing support group	Spiritually meaningful conversations
Laughter	Reflection: journaling, writing, meditating, poetry	Singing or listening to spiritual music
Limiting alcohol consumption	Movies, books, music	Contact with religious leaders
Therapeutic massage, sauna	Having balanced priorities	Time with art, nature or music
Repetitive activities	Understand traumatic stress and having realistic expectations	Solitude
	Counseling	

Headington Institute, 2008

Tips for supporting staff

Everyday Care	Support for Critical Events
Create a Supportive Climate	Watch for: suffering in silence and keeping a stiff upper lip
Establish Routines	Accommodate the Staff
Manage Information	Arrange for Defusing
Monitor Health and Well-being	Providing psychological interventions
Attend to Nutrition	
Monitor Alcohol Consumption	
Provide Exercise Opportunities	
Monitor Stress Levels	

UNHCR, 2001

SESSION THREE:
COMPLEX CCS SCENARIOS: SUICIDE, TRAFFICKING AND TRANSACTIONAL SEX

Suicide assessment

When to carry out a suicide assessment

- Sexual assault survivors may contemplate suicide, but is difficult to discuss
- Risk of a survivor committing suicide after making a suicidal statement varies among cultures.
- Suicidal statements should always be taken seriously by the care provider
- Need to establish: Is it *only* a feeling, or a feeling with intent to act?

Steps to assess suicide risk

Step 1: Assess current/past suicidal thoughts

Step 2: Assess risk: lethality & safety needs

Step 3: Address feelings & provide support LISTEN

Step 4: Formulate a safety action plan

Plenary discussion

- What are common attitudes towards suicide in your community?
- What makes it difficult to talk about suicide?
- How should suicidal children be handled?
- Discuss your experiences working with emotionally unstable or suicidal patients.

Would you like to discuss this issue further?

Asking About Suicide: Activity

Why talk about suicidal feelings?

Asking a survivor if s/he is suicidal may her /him an opportunity to talk about how s/he is feeling

- May help her / him to deal with those feelings
- May decrease sense of isolation & distress
- And may help reduce risk of attempting suicide

Listen carefully to response.

- An initial “I don’t know” or “no” may mean yes

- ALWAYS refer to qualified professional health workers for help

Steps to assessing suicide risk

STEP 1: If you are concerned a child might be suicidal

ACTION: Initiate suicide assessment

- Explain you have to ask hard questions & why
- Ask questions to assess suicidal thoughts

STEP 2: If child answers “YES” to above questions:

ACTION: Use probing questions

- Tell me about how you would end your life…
- Have you ever started to try to end your life but changed your mind? Or someone stopped you?

Step 3: Provide support &
Step 4: Formulate a plan

STEP 3: If child has no PLAN & no previous attempts – risk is less immediate

ACTION: Address feelings and provide support

STEP 4: If the child is able to explain a plan and/or indicate have already attempted suicide - risk is more immediate

ACTION: Formulate a safety action plan

Child Trafficking: Identification and Communication

Child Trafficking: The Background

"*A child has been trafficked if he or she has been moved within a country, or across borders,* ***whether by force or not****, with the purpose of exploiting the child"* – UNICEF.

- Existing Services
- Referral Pathways
- Our Role

Identification & Communication with Potential Child Trafficking Survivors

- Potential Warning Signs
  - Travel Patterns
  - Persons Travelling With
  - Purpose of Travel
  - Documentation
  - Incidents on Journey
- Questions to Ask
- Communication Techniques

INTERNATIONAL RESCUE COMMITTEE

SESSION FOUR: PRACTICAL

PART ONE: CASE STUDY 1

In Your Groups:

Decide on:

1. Next Steps for Case Management
2. Who Should Be Involved in the Case Management (e.g. Actors, Caregivers)
3. How the Guiding Principles Interact with Decisions Made

PART TWO: NEW PROBLEM

In Your Groups:

Decide on:

1. Next Steps for Case Management
2. Who Should Be Involved in the Case Management (e.g. Actors, Caregivers)
3. How the Guiding Principles Interact with Decisions Made

PART THREE:
DISCUSSION & LESSONS LEARNED

PART ONE: CASE STUDY 2

In Your Groups:

Decide on:

1. Next Steps for Case Management
2. Who Should Be Involved in the Case Management (e.g. Actors, Caregivers)
3. How the Guiding Principles Interact with Decisions Made

PART TWO: NEW PROBLEM

In Your Groups:

Decide on:

1. Next Steps for Case Management
2. Who Should Be Involved in the Case Management (e.g. Actors, Caregivers)
3. How the Guiding Principles Interact with Decisions Made

PART THREE:
DISCUSSION & LESSONS LEARNED

INTERNATIONAL RESCUE COMMITTEE

SESSION FIVE: Q & A