

# **SAFE<sub>AT</sub> HOME**

## **MODULE 2: WOMEN AND CHILDREN SAFE AT HOME**



## **Part 6: Intimate Partner Violence and Child Maltreatment Co-Occurrence Guidance**

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**For Writing:** Jessica Dalpe and Meghan O'Connor

**For Contribution of Expertise:** Gisele Okama, Daddy Bauma, Bertin Kanani, Joviale Luanda, Jean de Dieu Hategekimana, Martin Nyanguba, Eddy Bahiga, Rocky Kabeya, Yvonne Agengo, Amy Neiman, Haja Kakay, Patty Grey, Ricardo Pla Cordero, Pauline Thivillier, Sarah Mosely, Annalisa Brusati, Sandra Maignant.

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### International Rescue Committee

Agency Headquarters  
122 East 42nd Street  
New York, NY 10168  
  
USA  
tel.: +212 551 3000



## MODULE 2

# WOMEN AND CHILDREN SAFE AT HOME

## Part 6: Intimate Partner Violence and Child Maltreatment Co-Occurrence Guidance

|                                                                                          |           |
|------------------------------------------------------------------------------------------|-----------|
| <b>1. Introduction.....</b>                                                              | <b>4</b>  |
| <b>2. Assessment &amp; Initial Response to Co-Occurrence.....</b>                        | <b>11</b> |
| <b>3. Referrals for Co-Occurrence.....</b>                                               | <b>20</b> |
| <b>4. Collaboration for Co-Occurrence.....</b>                                           | <b>26</b> |
| <b>5. Case Conferencing for Co-Occurrence.....</b>                                       | <b>33</b> |
| <b>6. Supervision.....</b>                                                               | <b>36</b> |
| <b>7. References .....</b>                                                               | <b>38</b> |
| <b>ANNEX 1: Child-Centered Approach (CP).....</b>                                        | <b>41</b> |
| <b>ANNEX 2: Survivor-Centered Approach (GBV) .....</b>                                   | <b>42</b> |
| <b>ANNEX 3: Complimentary Differences in Child and Survivor Centered Approaches.....</b> | <b>43</b> |
| <b>ANNEX 4: Response Decision Tree .....</b>                                             | <b>45</b> |
| <b>ANNEX 5: Co-Occurrence Notation Form .....</b>                                        | <b>46</b> |
| <b>ANNEX 6: Sample Joint Safety Plan.....</b>                                            | <b>47</b> |
| <b>ANNEX 7: Case Conference Documentation Template.....</b>                              | <b>53</b> |
| <b>ANNEX 8: Co-Occurrence Case Management Reflection Tool .....</b>                      | <b>54</b> |

# 1. Introduction

Globally, one in three women will experience violence at some point in their lives,<sup>1</sup> and one in two children will experience some form of violence or abuse.<sup>2</sup> At least 30% of women around the world have experienced violence by an intimate partner, and 38% of murders of women are committed by a current or former intimate partner.<sup>3</sup> Violence in the home is the most common form of violence against girls and boys,<sup>4</sup> with four out of five children between the ages of 2–14 experiencing violent discipline, and 70% of children facing threats, intimidation, ridicule, and verbal or emotional abuse in the home. In humanitarian contexts, violence against these populations may be exacerbated by displacement, active conflict, and the breakdown of family units and legal systems, which ordinarily serve to protect women and children.<sup>5</sup> For violence against women and girls (VAWG) in humanitarian contexts, existing VAWG is exacerbated due to male control and power over women and girls. Situations of conflict, post conflict, and displacement may exacerbate both existing violence by intimate partners and non-partner sexual violence and may also lead to new forms of violence against women.<sup>6</sup> For violence against children in humanitarian contexts, protection from violence and access to healthcare and education are very limited, if not entirely unavailable. In these situations, children are increasingly exposed to neglect, as well as physical, emotional, and sexual violence. These forms of violence have been linked with a wide range of negative outcomes that are often shared between women and children, including poor mental health, physical health issues, reproductive health problems, developmental delays for children, and perpetuation of the cycles of poverty<sup>7</sup> and intergenerational violence. Recent evidence suggests that intimate partner violence (IPV) and child maltreatment co-occur within the home and share similar risk factors such as social norms that condone violence, men's abuse of power in the home, weak legal sanctions against violence, or harmful use of alcohol or drugs.<sup>8</sup> Men who perpetrate violence against their intimate partners are at higher risk of perpetuating abuse against children.<sup>9</sup>

Until recently, the humanitarian community has largely focused on violence against women and child maltreatment via separate and distinct interventions and strategies. While stand-alone programming can be effective, the effects of each type of programming can be amplified through collaborative approaches to addressing family violence with the goal of better safety outcomes for families. With funding from USAID's Bureau of Humanitarian Affairs, IRC began the pioneering work of addressing the co-occurrence of IPV and child maltreatment through the development of a family violence program model. The program model builds from best practices in IPV and child maltreatment prevention while advancing gender-based violence (GBV) and child protection (CP) case management guidance on how to best address co-occurrence within service provision. This document was created as part of this project – Safe at Home – to ensure that prevention efforts addressing the co-occurrence of IPV and child maltreatment within families have complimentary response efforts that address co-occurrence.

The purpose of this document is to outline how Child Protection (CP) and Gender Based Violence (GBV) caseworkers can identify, respond to, and coordinate on cases where there is IPV and child maltreatment happening within the same family unit. It is not meant to take the place of existing program guidance or to fill gaps when sector-specific programming does not exist; rather, it is meant to foster a greater understanding of co-occurrence and to promote positive working relationships between CP and GBV case management providers. This guidance is built upon the foundational understanding that GBV and CP caseworkers and supervisors are able to provide grounded, strong services for their respective client pools and that specialization of services is essential for survivor and child-centered care.

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<sup>1</sup> WHO, 2013. Full citation for all footnotes available in "References."

<sup>2</sup> Hillis et al., 2016.

<sup>3</sup> WHO, 2013.

<sup>4</sup> WHO, 2016.

<sup>5</sup> Annan & Brier, 2010; UNODC, 2018.

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<sup>6</sup> WHO, 2016.

<sup>7</sup> Hillis, Mercy & Saul, 2017.

<sup>8</sup> Guedes et al., 2016.

<sup>9</sup> Silverman et al., 2004.

## SECTION A

## KEY DEFINITIONS

**Intimate Partner Violence (IPV):**

Also referred to as domestic violence, IPV is a pattern of abusive behavior in an intimate relationship that is used by one person (who is usually a man) to gain or maintain power and control over the other person (who is usually a woman).<sup>10</sup> Intimate partner violence disproportionately affects women as societal expectations of the roles of men and women (gender roles) often support men's use of power over women in intimate partner relationships.

**Child Maltreatment:**

This is any action, including the failure to act, that results in harm, potential for harm, or threat of harm to a child. Maltreatment is commonly used as an umbrella term for abuse and neglect.<sup>11</sup>

**Family Violence:**

IRC defines family violence as co-occurring violence against women, children, and other at-risk populations within the home, perpetrated by family members. It may include intimate partner violence, child maltreatment, and abuse and neglect of older persons. Family violence is driven by embedded, socially reinforced power inequity stemming from patriarchal culture and perpetuated by a variety of risk factors unique to each family's circumstances.

**Co-occurrence:**

Co-occurrence is multiple forms of violence happening within the home at the same time. IPV and child maltreatment, in particular share common risk factors and drivers.

**Severe Harm:**

Throughout this guidance, there will be references to children being at risk of serious or severe harm. **Severe harm**<sup>12</sup> is defined as a situation in which the child has suffered or is likely to suffer significant impairment to her/his health or development, including sexual and physical abuse. Determining if and when a child is at risk of being seriously harmed can be difficult and is largely based on that child's individual and unique circumstances. In general, when determining a child's level of risk for harm, the following should be taken into account:

- The child's age, developmental stage, and disability status
- The existence of a connection between the harm to the child and the actions or inactions of the child's caregiver/guardian.
- Harm includes maltreatment, which involves the quality of care the child receives, and abuse which involves injury that allows or creates the opportunity for risk of death or impairment of physical or emotional health or impairment of the function of any bodily organ.
- Harm could include routine hitting, shaking, suffocating, drowning, denial of food or shelter, or throwing of objects at or toward the child.

For further guidance and information on determining child safety in humanitarian contexts, please reference the [Guidelines on Assessing and Determining the Best Interest of the Child](#), the [Toolkit on Unaccompanied and Separated Children](#), and the [Interagency Guidelines for Case Management & Child Protection](#).

<sup>10</sup> GBVIMS Steering Committee, 2017.

<sup>11</sup> Child Protection Minimum Standards, 2019.

<sup>12</sup> New York, 2016

## SECTION B

### FOUNDATIONAL APPROACHES & GUIDING PRINCIPLES

Both the CP and GBV sectors have highly developed case management approaches that are rooted in relevant theory, practice, and research.

For the CP sector, this is the **Child-Centered Approach** ([Annex 1](#)) which places the child and his/her needs at the center of the case management response and guides any decisions made with and for the child. The aim of the child-centered approach is to support the child and ensure his/her rights are fully respected and upheld throughout the process. For the GBV sector, this is the **Survivor-Centered Approach** ([Annex 2](#)) which aims to create a supportive environment in which each survivor's rights and wishes are respected and in which the survivor is treated with dignity and respect.

This guidance draws from both of these approaches to support the safety, healing, and recovery of both women and children who are experiencing violence in the same household.

#### Guiding Principles

The CP and GBV sectors have a host of guiding principles – many of which are shared and some of which are unique – all of which must be used to safely and compassionately address co-occurring IPV and child maltreatment.

#### SHARED GUIDING PRINCIPLES ACROSS THE CP & GBV SECTORS

- Do no harm
- Maintain confidentiality
- Non-discrimination
- Recognize innate child and survivor resilience
- Provide culturally appropriate care
- Adhere to ethical standards
- Adhere to informed consent (assent for children)
- Empowerment of women and girls, and children and families
- Establish and ensure safety
- Ensure accountability
- Coordinate and collaborate
- Maintain professional boundaries
- Observe mandatory reporting laws and policies where possible (for situations where mandatory reporting requirements put a survivor at further harm we do not follow them), ensuring access to services after taking into consideration safety/security risks and fully informing children and survivors of the limits of confidentiality and mandatory reporting requirements.

#### CHILD PROTECTION (CP)

- Ensure the best interests of the child; ensure that all decisions and actions taken uphold and promote the child's best interests at all times
- Facilitate meaningful participation of children (respecting their right to be heard, and giving due weight to their wishes in line with their evolving capacities)
- Base actions on sound knowledge of child development, child rights and child protection

#### GENDER-BASED VIOLENCE (GBV)

- Be survivor-centered: respect the self-determination of the survivor (i.e., the wishes, rights, and dignity of the survivor)
- Listen to the survivor, inform the survivor about all options; do not advise
- Recognize that VAWG is rooted in women's oppression and addressing GBV includes addressing gender inequality

## Similarities Across Approaches

CP and GBV approaches to case management share common ground that must drive the response to co-occurrence, including that both sectors:

- ☑ Want to end IPV and child maltreatment
- ☑ Want children to be safe
- ☑ Want adult survivors to be safe – for their own safety and so their children are not harmed by the violence
- ☑ Believe in empowering caregivers to build upon their strengths
- ☑ Believe in supporting the child-caregiver relationship

Additionally, both CP and GBV sectors approach the work from similar perspectives grounded in the social work model. These perspectives prioritize:

- a. **The Socio-Ecological Framework:** The socio-ecological framework, which is used in both GBV and CP approaches, takes into account the survivor or child's physical and social environment – the people and things in the immediate environment (home, community), and how these interact with the broader attitudes and beliefs, and social, political, and economic conditions to impact the survivor and child. This includes (1) the individual's living situation; (2) their financial situation; (3) supportive adults or people in their life; (4) the larger context in which they live, such as a conflict or disaster and the legal and governance structures in place to protect children and survivors; and (5) the broader systemic and societal forces in their life, such as patriarchal values and restrictive gender norms.
- b. **Safety, Recovery From Harm, and Protection From Further Harm:** Both CP and GBV services aim to help survivors and children find safety after being exposed to abuse, neglect, and/or exploitation, recover from their experiences of harm, and build protective factors to prevent them from experiencing further harm.
- c. **A Strengths-Based Approach:** Being strengths-based, or focusing on the protective factors, resources, support, and capacities that individuals and families have, is an approach used in both GBV and CP services. This includes identifying individual and community capacities and involving supportive individuals in the survivor or child's life.
- d. **Understanding Identities:** Both CP and GBV approaches to services are attentive to the many different components of a person's identity and how those identities interact to shape that person's experiences. For example, a person's gender, age, and developmental stage, disability status, sexual orientation, ethnicity, race, religion, social standing, economic situation, and many other identities factor into their day-to-day lived experiences of harm, safety, and access to support and services.

## **ATTITUDES & BELIEFS FOR RESPONDING TO CO-OCCURRENCE**

In addition to the guiding principles already established, the following attitudes and beliefs are essential when approaching cases of co-occurring IPV and child maltreatment:

1. Children are not to blame for maltreatment that occurs to them or the IPV that occurs between their caregivers.
2. Children are emotionally and psychologically harmed by IPV in the home<sup>13</sup> and all humanitarian actors have a responsibility to safeguard children.
3. Women and children who share their experiences of IPV and child maltreatment are to be believed.
4. Women and children are inherently resilient and can heal from experiences of IPV and child maltreatment.
5. By helping survivors of IPV access services, the well-being of their children is also enhanced.
6. Survivors of IPV are not to blame for the violence they experience or the effects of IPV on their children.
  - a. IPV abusers often use children to control, intimidate, or threaten their partner.
  - b. Women who stay with an abusive partner are not to be blamed for harm to children by their partners (both directly and as a witness to IPV). For example, a mother should not be considered responsible for protecting her children from her abuser. There are many reasons why women choose to stay with an abusive partner – many of which are related to the survival and safety of her family.
7. In circumstances where survivors of IPV are abusive towards their children, responses must address their victimization and acknowledge that the violence they experience contributes to the violence they perpetrate.<sup>14</sup>

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<sup>13</sup> Bragg, 2003.

<sup>14</sup> Current research indicates a complex relationship between surviving IPV and engaging in abusive parenting behaviors, pointing to the fact that parenting changes with time and is impacted by context. For example, in one study, the impact of IPV on women's parenting changed over time as the severity and presence of IPV changed, showing an improvement in parenting with a reduction or elimination of IPV. Additionally, further studies have also found that female caregivers who experience IPV may be more sensitive and responsive to their children than parents who have not experienced IPV, demonstrating their desire to mitigate the negative impacts of witnessing IPV on their children's wellbeing (Greeson et al., 2014; Levendosky et al., 2006; Levendosky & Graham-Berman, 1998; Letourneau et al., 2007).

## SECTION D

## ROOT CAUSES, RISK FACTORS, &amp; DRIVERS FOR CO-OCCURRENCE

Recent evidence suggests that IPV and child maltreatment share similar root causes, risk factors, and drivers, such as social norms that condone violence, unequal gender and power structures in the home, weak legal sanctions against violence, or harmful use of alcohol or drugs.<sup>15</sup> More specifically, some shared root causes and risk-factors include:

**Root Causes<sup>16</sup>**

- a. **Patriarchal Culture:** A set of social roles, responsibilities, norms, and practices that are born from power inequity, where men have systematic and socially-accepted power and control over women and children. In patriarchal culture, men are valued above women and children, and may use power and privilege to enact violence. Women may also internalize patriarchal values and norms and enact them upon their children.
- b. **Violence as a Form of Discipline and Control:** The acceptance of violence as a means for “correcting,” controlling, or demonstrating anger against perceived noncompliance with socially expected behavior.
- c. **Power and Gender in the Home:** In many cultures, gender and social norms often indicate that men are the head of the household with all the power and authority over the family; women must obey men, and children must obey adults (both male and female caregivers). The abuse of power often manifests in violence against women, girls, and boys.

**Risk Factors**

- a. **Alcohol and Substance Use:** Alcohol and substance use can contribute to men’s use of violence against women and children.<sup>17</sup>
- b. **Economic Insecurity:** The stressors caused by economic insecurity are often cited as a driver of violence against women, children, older persons, and persons with disabilities.<sup>18</sup>
- c. **Prior Victimization:** Experiencing violence in the past, whether as a child witnessing violence between caregivers, being maltreated as a child, or having prior violent and controlling relationships, can put an individual at further risk for experiencing and perpetrating violence in relationships with partners and children.<sup>19</sup>

**Engaging With Abusers**

An important difference to note between the approaches of CP and GBV to family violence is that CP regularly and purposefully engages with abusive caregivers, while GBV programs intentionally do not engage with abusive partners. This difference is a great strength in the approach to co-occurring IPV and child maltreatment and should be fully understood. The rationale for each sector’s approach to working with abusers is explained below.

<sup>15</sup> Guedes et al., 2016.

<sup>16</sup> Asghar, Pardo & Falb, 2018.

<sup>17</sup> *Ibid.*

<sup>18</sup> *Ibid.*; Guedes et al., 2016.

<sup>19</sup> Levesque et al., 2007.

## GBV

### **In CP programming, abusers are regularly engaged in CP services for a number of similar reasons:**

While there are deep rooted social and cultural norms that reinforce caregivers' power over and right to discipline their children, these norms are not supportive of harmful or abusive behavior towards children. Generally speaking, social and cultural norms across cultures and contexts reinforce the idea that parents and caregivers' role is protective and nurturing. For this reason, the motivation to change abusive parenting techniques and approaches not only exists but is supported by social and cultural norms. Finally, there is a humanitarian imperative to protect all girls and boys under the age of 18; therefore, professionals must act on behalf of children, in line with their developmental age and capacity, and promote their safety and wellbeing, assessing and ensuring the best interest of the child at all times.

### **In GBV programming, abusers are never engaged in services for a number of reasons:**

First and foremost, doing so could put survivors and their children at increased harm. Survivors often experience reprisal actions and increased abuse— in many cases life threatening— against them and their children if perpetrators are aware that they have sought help. Furthermore, men who abuse women do so within social and cultural norms that reinforce their power over and right to abuse women (see the definition of patriarchy above). Because violence against woman and girls is rooted in systems across cultures and contexts, there is often very little motivation for abusive men to change their behavior. In fact, their behavior is often encouraged, or at best, ignored by society at large. Moreover, in contexts where perpetrator treatment programs have been developed, the effectiveness of this programming is inconsistent and inconclusive, at best, with few programs showing sustained effects. Finally, in maintaining the survivor-centered approach ([Annex 2](#)), it is not within a professional's mandate to act on behalf of the survivor or intervene in her best interest because she has the right to self-determination, and she also knows her situation best.

## 2. Assessment & Initial Response to Co-Occurrence

Before co-occurrence response work is undertaken, it is imperative that there are established case management services within the CP and GBV programs. This includes trained caseworkers who have regular supervision, standard operating procedures (SOPs), service directories and referral pathways, and adequate financial and material resources, etc. Addressing co-occurrence is not a stand-alone project and requires the collaborative efforts of both CP and GBV programs.

### SECTION A

#### WARNING SIGNS FOR CO-OCCURRENCE

GBV and CP caseworkers should be aware of warning signs among children and adults that IPV and child maltreatment may be co-occurring. Caseworkers should be mindful of the presence of multiple warning signs and should carefully and safely attempt to gather more information when the types of situations below present. Some warning signs include:

- Marital disputes without apparent physical violence<sup>20</sup>
- Children demonstrating aggressive or violent behavior towards the female caregiver (mirroring abuser's behavior) or towards others
- Children assuming adult responsibilities
- Children not wanting to be away from a female caregiver
- Male and/or female caregivers using physical punishment to discipline children
- Children and/or female caregivers being frequently absent from services or school
- Body language and nonverbal communication (e.g., wincing or changing behavior in others' presence)
- Secrecy or atypical discomfort discussing relationships
- Overly protective or controlling partners/caregivers
- Delays in seeking medical care for injuries of children and/or female caregiver
- History of repeated medical treatment for fractures, concussions, burns, or other physical injuries.
- Isolation from friends and family

**It is important to note that some of these warning signs may be normal reactions during a humanitarian emergency or displacement and should not be taken as sure signs that child maltreatment or IPV are definitely occurring.**

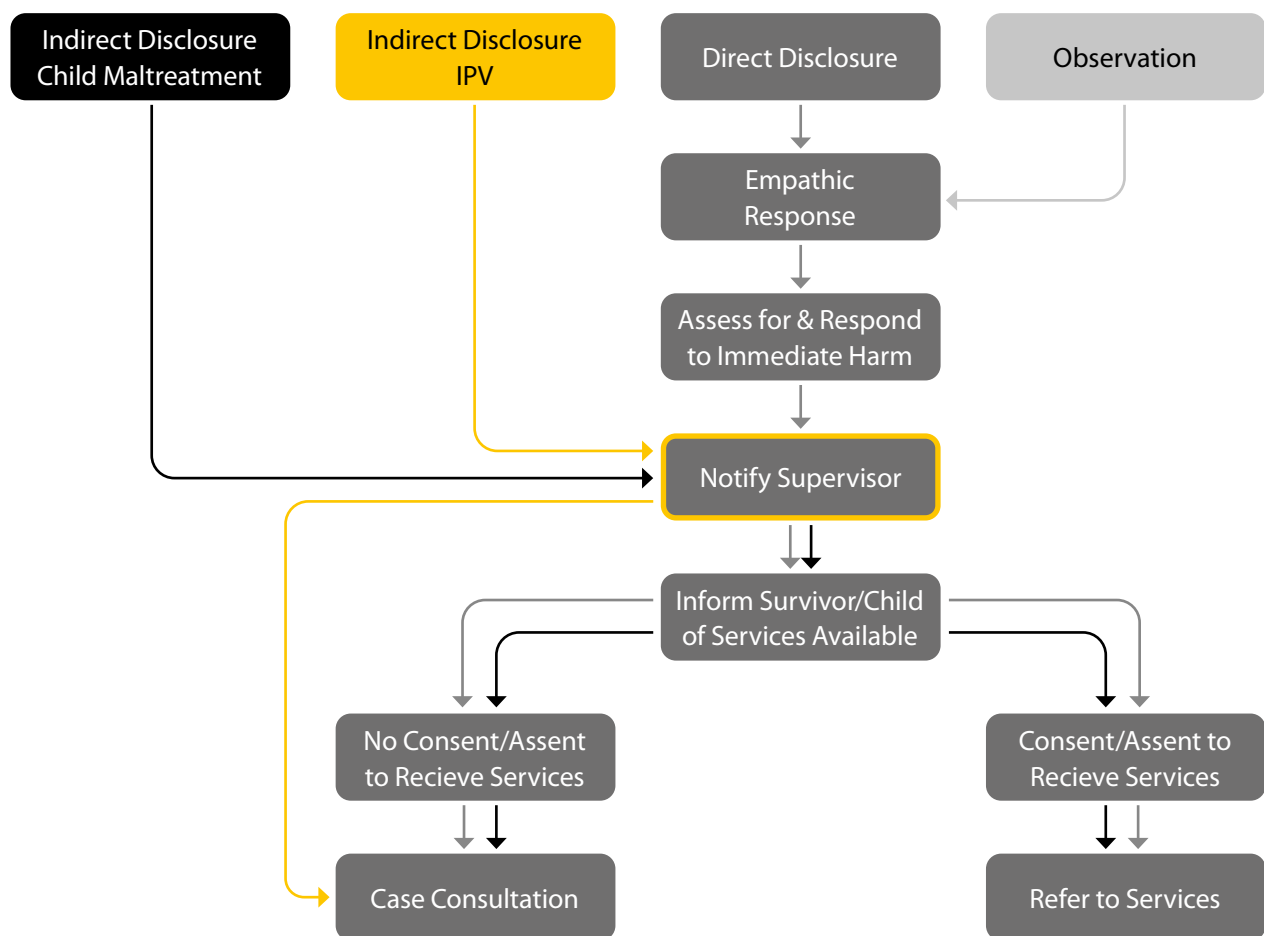
<sup>20</sup> Jaffe et al., 2014.

## Assessment & Initial Response

Appropriate assessment of co-occurring IPV and child maltreatment is imperative to successfully supporting survivors and children. It is also a very sensitive process that can have the potential to further exacerbate the violence that is occurring within the family. For this reason, it is important to approach this discussion with caution and skill.

The two sections below, “Guidance for Child Protection Caseworkers” and “Guidance for GBV Caseworkers,” outline specific recommendations for CP and GBV caseworkers to safely assess and appropriately respond to co-occurring IPV and child maltreatment. They are for **caseworkers who are already working with children and/or female caregivers who are survivors of IPV through case management services.**

The initial response for caseworkers, in its simplified form, should generally follow the diagram below ([Annex 4](#)).



The diagram is organized by type of disclosure – *indirect disclosure*, which is a situation in which someone other than the individual experiencing the violence tells a caseworker about the violence, and *direct disclosure*, which is a situation in which the individual experiencing the violence tells a caseworker about her/his experience of violence. When going through the basic response steps, it is important to ensure that the steps are completed in a timely manner. Best practice is for caseworkers to assess for and respond to harm in the moment and to notify supervisors before the end of the day in which the co-occurrence became known. Generally speaking, follow-up with the child and survivor should occur within one day of learning of the co-occurrence through a direct disclosure and within three days of an indirect disclosure. Below, these steps are described in further detail, adding in nuance related to children’s ages, and best practices according to the survivor and child centered approaches.

## SECTION B

## GUIDANCE FOR CHILD PROTECTION CASEWORKERS

**Entry point for assessment and response for co-occurrence:** Maltreatment of child has already been identified and child and caregiver(s) are already engaged in child protection services.

During the assessment step of the case management process, before learning of any co-occurring IPV, CP caseworkers should provide the opportunity for disclosure through the suggested guidance below.

### Facilitating Disclosure of Co-Occurrence (Assessment)

It is best to approach the conversation about IPV with a female caregiver from a general perspective, framing it as part of the assessment usually carried out with parents/caregivers. This will give her the opportunity to disclose experiences of violence if and when she feels comfortable doing so rather than asking direct questions about IPV. This is done to maximize the safety of the children and the female caregiver who could experience backlash from an abuser if he becomes aware that others know about the violence he is perpetrating (see [survivor-centered approach - Annex 2](#)). Best practices in assessing for IPV within the assessment for female caregivers include:

- Having a female caseworker speak with the female caregiver in a private space;
- Ensuring the caseworker has established a trusting and safe relationship with the female caregiver before incorporating questions about IPV into the assessment;
- Emphasizing the universal nature of the assessment (i.e., explaining that all female caregivers are given the opportunity to discuss their safety within their family).

A suggested script for approaching this conversation is below. As programs begin to think about using the sample script in case management, it is important to contextualize it so that the language is reflective of the culture in which services are being provided,



#### SAMPLE SCRIPT:

*"We tell all the women we support that our services is a safe place to talk about experiences of violence and family relationship problems. We bring this up because some of the women we see here have been hurt by a family member, someone they know, or a stranger. This can happen in the camp, back home, or anywhere. Sometimes women don't want to talk about being hurt since they think it is very personal, that no one will understand, or that it was their fault. We understand this can be hard to talk about. I don't know if anything like this has happened to you, but I want you to know that you can tell me at any time, and I will keep what you tell me private and confidential. [If you want to tell someone but prefer to talk to someone else, let me know and I can connect you to one of my colleagues for support.] We can help connect women who have been or are being hurt to support and help. Do you have any questions about this?"*

*"Thank you for letting me talk to you about this. We are here if you ever need help."<sup>21</sup>*

<sup>21</sup> Wachter & Donahue, 2015.

## Responding to Disclosure of Co-Occurring IPV

There are several ways in which a CP caseworker may find out that the child with whom they are working has a female caregiver in an IPV situation. This could be through (1) **direct disclosure**, when the caseworker is told about the abuse from the female caregiver; (2) **indirect disclosure**, when the caseworker learns about the IPV from the child or anyone other than the survivor; or (3) when the caseworker learns about the IPV through **observation**. These scenarios require different responses (outlined below).

### 1 Direct Disclosure

A. **If a child's female caregiver discloses IPV to a CP caseworker**, the CP caseworker will:

1. Respond with empathy by allowing the survivor to determine how much s/he wants to disclose and listen without judgment.
2. Assess for and respond to any harm to the child and other children in the home.
3. Notify their supervisor.
4. Inform the survivor about available services and options for getting help, such as the availability of GBV services and dedicated caseworkers who can help the survivor address her safety and that of her children. This should include providing information about additional places/services such as a women's center and surrounding activities, which do not require a disclosure of IPV. Inform the survivor about limits to confidentiality such as suicide or mandatory reporting laws for IPV, if applicable.
  - a. If the survivor **is interested** in receiving GBV services, consent must be obtained, and a referral must be made to GBV. See [Chapter 3, Section A](#) for more guidance.
  - b. If the survivor **is not interested** in services, the caseworker should meet with their supervisor and a GBV supervisor or caseworker for consultation on the best ways to address such a case according to GBV guiding principles and the survivor-centered approach, taking care to maintain confidentiality and not share any identifying information, if the GBV program is not already involved.

### 2 Indirect Disclosure

A. **If a child discloses IPV to a CP caseworker**, the CP caseworker will:

1. Respond with empathy to the child, being sure to remind the child that the violence between her/his caregivers is not in that child's control and is not her/his fault.<sup>22</sup>
2. Assess for and respond to any harm or potential harm to the child or other children in the home.
3. Notify their supervisor.
4. Meet with their supervisor and a GBV supervisor or caseworker for consultation on the best ways to address such a case according to GBV guiding principles and the survivor-centered approach, taking care to maintain confidentiality and not share any identifying information.<sup>23</sup>
  - a. This consultation should include discussions regarding safe entry points for GBV services, and the appropriateness and safety of addressing IPV with the female caregiver.



#### SAMPLE SCRIPT:

*"Thank you for talking to me about this. You are so brave to share that with me. I know sometimes it can feel like what happens between mom and dad can be caused by things you have or haven't done, but it is never your fault."*

<sup>22</sup> Domestic Violence Prevention Council, 2014

<sup>23</sup> Identifying information includes names, locations, specifics of the circumstances or violence, etc.

5. If appropriate and available, explore additional child-centered interventions such as child-friendly safe spaces, life skills courses, etc., with the child and her/his caregiver. These interventions should be framed as additional supports for the child in general, without mention of IPV.
6. Continue to monitor the child to assess if they are being maltreated by either caregiver.

**B. If a CP caseworker learns from a third party about IPV** (i.e., the information is provided to the CP caseworker by someone other than the child or the child's female caregiver), the CP caseworker will:

1. Meet with their supervisor and a GBV supervisor or caseworker for consultation on the best ways to address such a case according to GBV guiding principles and the survivor-centered approach, taking care to maintain confidentiality and not share any identifying information, if the GBV program is not already involved.

### ③ Observation

**A. If a CP caseworker directly observes IPV occurring**, the CP caseworker will:

1. Find a time to meet privately with the survivor to respond with empathy and without judgment. The CP caseworker should **NOT** attempt to directly intervene or address the IPV as it is happening for the caseworker's safety and that of the survivor and child.
2. Assess for and respond to any harm to the child(ren) or survivor.
3. Notify their supervisor.
4. Inform the survivor about available services and options for getting help, such as the availability of GBV services and dedicated caseworkers who can help the survivor address her safety and that of her children. This should include providing information about additional places/services like the women's center and surrounding activities, which do not require a disclosure of IPV. Inform the survivor about limits to confidentiality such as suicide or mandatory reporting laws for IPV, if applicable.



#### SAMPLE SCRIPT:

*"I noticed the other day that your husband/partner [hit, pushed, used violence, etc.]. I am so sorry you are going through this. Sometimes caregivers we work with experience violence in their relationships, and many find that talking with a professional about it can help. I would be happy to connect you to one of my colleagues for support."*

- a. If the survivor **is interested** in receiving GBV services, consent must be obtained, and a referral must be made to GBV. See [Chapter 3, Section A](#) for more guidance.
- b. If the survivor **is not interested** in services, the caseworker should meet with their supervisor and a GBV supervisor or caseworker for consultation on the best ways to address such a case according to GBV guiding principles and the survivor-centered approach, taking care to maintain confidentiality and not share any identifying information, if the GBV program is not already involved.

## SECTION C

### GUIDANCE FOR GBV CASEWORKERS

**Entry point for assessment and response of co-occurrence:** Survivor (female caregiver) is already receiving services for IPV and there is a disclosure of child maltreatment.

During the assessment step of the case management process, before learning of any co-occurring child maltreatment, GBV caseworkers should assess for child safety through the suggested guidance below.

#### Facilitating Disclosure of Co-Occurrence (Assessment)

Part of the GBV caseworker's assessment with an IPV survivor should also include assessing for the needs, wellbeing, and safety of the survivor's children.<sup>24</sup> For many survivors, the impetus to act and seek help is directly related to their children's safety and therefore may be a large aspect of their case action plan. In discussing with survivors their needs and perceptions of safety, GBV caseworkers can also assess the needs and safety of the children. In addition to learning more about the survivor's family composition (i.e., how many children she has, their ages, and if they are enrolled in school or programming), the GBV caseworker should also learn more about the children's safety. The caseworker should begin by asking the survivor about her children's well-being and the potential impact the violence is having on the children using the suggested questions below. It is also important for the caseworker to understand how the violence is impacting the survivor's ability to care for and parent her children.

- ☒ How is the violence affecting your children?
- ☒ Have you noticed any of your children acting differently? For example, acting protective of you, clinging to you, acting out in school or at home? Tell me more about their behavior changes.
- ☒ Have your children ever witnessed, intervened, or been physically harmed when your partner is hurting you?
- ☒ Have your children ever been injured because they have been present during a violent incident?
- ☒ Has your partner ever threatened to hurt or harm the children as a way to hurt or punish you?
- ☒ Has your partner ever hurt the children?
- ☒ Has your relationship with your children changed as a result of the violence? If so, how?

It is important that these questions are asked in a way that is not judging or holding the survivor responsible for what may be happening with her child(ren). Before asking any of the above questions, emphasize that they are not to blame. Additionally, female caregivers may want support for their own parenting practices. Some survivors of IPV may also engage in abusive behavior towards their children. This behavior is intricately and complicatedly linked to the survivor's own experience of IPV. In being survivor-centered, it is important for caseworkers to introduce this portion of the assessment using validation, normalization, and non-threatening language.

<sup>24</sup> GBVIMS Steering Committee, 2017.

A sample script to introduce that can be found below:



#### SAMPLE SCRIPT:

*"Many mothers/female caregivers who are experiencing IPV expend a lot of energy surviving and helping their children survive. Sometimes the stress of the violence and the stress of being a mother can make parenting difficult. For example, setting boundaries, managing children's behavior, and applying discipline, which are all difficult tasks in the best of circumstances, can become nearly impossible when also managing partner violence. Some mothers we work with find it helpful to talk to someone about ways they can get support for parenting their children. If this is something you'd be interested in, let me know and we can talk about connecting you to one of my colleagues for support. Would you be interested in exploring services to help you set boundaries for your children and discipline them?"*

## Responding to Disclosure of Co-Occurring Child Maltreatment

There are several ways in which a GBV caseworker may find out that the child of a survivor with whom they are working is being maltreated. This could be through (1) **direct disclosure**, when the caseworker is told about the abuse from the female caregiver or the child or when the caseworker learns about the child maltreatment through **observation**; or (2) **indirect disclosure**, when the caseworker learns about the child maltreatment from a third party. These scenarios require different responses (outlined below).

### 1 Direct Disclosure

**A. If an IPV survivor discloses to a GBV caseworker that her child has been harmed or is at risk of being harmed, or if the caseworker directly observes child maltreatment** – this may include harm from the abuser and/or from the survivor herself – the GBV caseworker will:

1. Respond with empathy by allowing the survivor to determine how much s/he wants to disclose and listening without judgment.
2. Notify their supervisor.
3. Inform the survivor about available services and options for getting help, such as the availability of child protection services and dedicated caseworkers who can help the survivor address the safety of her child(ren). Inform the survivor about limits to confidentiality such as mandatory reporting laws for child maltreatment, if applicable.
  - a. If the child is too young or unable to give consent (under the age of 15)<sup>25</sup> and the child/survivor is interested in receiving CP services, consent must be obtained from the survivor and assent from the child and a referral must be made to CP. See [Chapter 3, Section A](#) for more guidance.
  - b. If the child is an older adolescent and able to consent (depending on local laws), the child may be referred to CP services directly. Services for other children in the home should also be explored.



#### SAMPLE SCRIPT IF THE ABUSER IS HARMING THE CHILDREN:

*"Thank you for sharing your concern for your child with me. It's clear to me that you love your child very much and want the best for her/him."*



#### SAMPLE SCRIPT IF THE SURVIVOR IS ALSO HARMING THE CHILDREN:

*"Thank you for sharing what is happening in your home. I just heard you mention that your child is being harmed. Let's talk further about how to make sure both you and your child are safe from harm."*

<sup>25</sup> CCS Guidelines.

4. If the survivor and or child are not interested in services and the child is in life-threatening danger, the GBV caseworker should speak with the survivor to better understand her concerns and explain the possible outcomes. If appropriate and possible, the GBV caseworker can have this conversation with the survivor and a CP caseworker to help build rapport and trust for CP services. Because survivors' refusal to access help for their children is often closely tied to fear of the repercussions of doing so – Will the children be taken away from her? Will they be at risk for more abuse from the abuser? Could she lose custody of the children? – the two caseworkers should jointly assess safety concerns and make a safety plan.



#### SAMPLE SCRIPT IF THE CASEWORKER OBSERVES THE SURVIVOR HARMING THE CHILDREN:

*"Sometimes the stress of the violence and the stress of being a mother can make parenting difficult. Some mothers we work with find it helpful to talk to someone about ways they can get support for parenting their children. I would be happy to connect you to one of my colleagues for support."*

- a. Following such a joint conversation, if the survivor still chooses not to pursue services, the caseworker should immediately contact their supervisor and a CP supervisor or caseworker for immediate referral and support to the child. The GBV caseworker should clearly explain to the survivor that the risks the child is facing, and the mandatory reporting laws require them to inform CP services immediately. The GBV caseworker should prepare the survivor as much as possible for the likely outcomes.
5. If the survivor and/or child is not interested in services, and the child is **not** in immediate danger, the caseworker should meet with their supervisor and a CP supervisor or caseworker for consultation on the best ways to address such a case according to CP guiding principles and the child-centered approach, taking care to maintain confidentiality and not share any identifying information (if the CP program is not already involved).
  - a. This consultation should include discussions regarding safe entry points for CP services, and the appropriateness and safety of addressing child maltreatment with the survivor.

In some cases, the child of a survivor may come into contact with a GBV caseworker. For example, this could happen if the child participates in awareness-raising sessions led by the GBV caseworker, is involved in childcare in a women and girls' safe space or if the child knows the GBV caseworker personally from prior contact.

#### **B. If the child of a survivor currently receiving services discloses to a GBV caseworker that s/he has been harmed or is at risk of being harmed, the GBV caseworker will:**

1. Respond with empathy by allowing the child to determine how much s/he wants to disclose and listening without judgment.
2. If the child is severely harmed or at risk of being severely harmed and depending on local laws (see definition of *severe harm* in [Chapter 1, Section A](#)), the caseworker is mandated to act in the best interest of the child by involving Child Protection staff without the child or survivors' consent.
3. Notify their supervisor.
4. If the child is an older adolescent and able to consent (based on what is considered the local age of consent), the child may be referred to CP services directly.



#### SAMPLE SCRIPT:

*"Thank you for talking to me about this. You are so brave to share that with me."*

5. If the child is too young or unable to give consent, ask the child if s/he is comfortable with the caseworker involving their female caregiver (IPV survivor).
  - a. If the child assents, involve the child and caregiver in a discussion about the child receiving case management services.
    - If there is interest in engaging in CP services, consent must be obtained from the survivor and assent from the child and a referral must be made to CP. See [Chapter 3, Section A](#) for more guidance.
    - If the survivor and/or child is not interested in services, and the child is not in immediate danger, the caseworker should meet with their supervisor and a CP supervisor or caseworker for consultation on the best ways to address such a case according to CP guiding principles and the child-centered approach, taking care to maintain confidentiality and not share any identifying information (if the CP program is not already involved).
    - This consultation should include discussions regarding safe entry points for CP services, and the appropriateness and safety of addressing child maltreatment with the survivor.
  - b. If the child does not assent to their female caregiver's involvement, and the child is not in immediate danger, the GBV caseworker should meet with their supervisor and a CP supervisor or caseworker for consultation on the best ways to address such a case according to CP guiding principles and the child-centered approach, taking care to maintain confidentiality and not share any identifying information (if the CP program is not already involved).
    - This consultation should include discussions regarding safe entry points for CP services, and the appropriateness and safety of addressing child maltreatment with the survivor.

## 2 Indirect Disclosure

**A. If a GBV staff suspects child maltreatment or learns from a third party about child maltreatment** in the context of providing services to the child's female caregiver (i.e., the information is provided to the GBV caseworker by someone other than the child or the child's caregiver), the GBV caseworker will:

1. Notify their supervisor.
2. If the caseworker has reason to believe the child is severely harmed or at risk of being severely harmed, and depending on local laws, the caseworker is mandated to act by involving Child Protection staff without the survivor or child's consent.
3. Meet with the survivor to assess for child maltreatment. Explain to the survivor that they are concerned about the safety of the survivor's child(ren). Educate the survivor about available services and options for getting help, such as the availability of CP services and dedicated caseworkers who can help the survivor address the safety of her children. Inform the survivor about limits to confidentiality such as mandatory reporting laws for child maltreatment, if applicable.
  - a. If the survivor is interested in receiving services, consent must be obtained, and a referral must be made. See [Chapter 3, Section A](#) for more guidance.
  - b. If the survivor is not interested in services, and the child is not in immediate danger, the caseworker should meet with their supervisor and a CP supervisor or caseworker for consultation on the best ways to address such a case according to CP guiding principles and the child-centered approach, taking care to maintain confidentiality and not share any identifying information (if the CP program is not already involved).
    - This consultation should include discussions regarding safe entry points for CP services, and the appropriateness and safety of addressing child maltreatment with the survivor.

# 3. Referrals for Co-Occurrence

This section pertains to referrals made between GBV and CP service providers and applies to referrals within the same organization and referrals between external partners.

## SECTION A

### MAKING SUCCESSFUL REFERRALS

For a referral system to work at its best, relationships between service providers need to be formalized. This includes each provider having:

- ☑ Clarity about their roles, responsibilities, and limitations
- ☑ Readily available services for the population
- ☑ Understanding of each other's service and ability to explain each other's services in a safe way
- ☑ Knowledge of the overall accessibility of information and physical environment, and the capacity for the provision of reasonable accommodation to address potential barriers for clients with disabilities
- ☑ Agreed upon means of communication between organizations, units, or departments within one organization
- ☑ Identified focal points in each organization, unit, or department to be the liaison for referrals

When discussing and establishing roles, responsibilities, and limitations, it is suggested to begin with the following delineations between GBV and CP service providers:

- GBV service providers will primarily be responsible for assessing, responding to, and supporting the survivor around IPV, including a review of the dynamics of IPV, services available for survivors and their families, and safety planning for the survivor/child(ren).<sup>26</sup>
- CP service providers will primarily be responsible for assessing, responding to, and supporting children and their caregivers around child abuse and neglect, including reviewing the impact of violence on children, services available for children and their families, and safety planning for the children.<sup>27</sup>

When attempting to make a referral with the survivor/child(ren) and their caregiver, it is important for caseworkers to give the survivor/child(ren) relevant information such as:

- ☑ Reasons and importance of the referral
  - **Referrals to Child Protection Services:** When referring to CP services, it is important to emphasize the additional support a survivor can receive for her children and additional services her children can access. This includes ensuring the children are safe and that the survivor has resources to help her address their needs, such as parenting support. This can also include child-centered activities such as safe spaces, life skills, and safe healing and learning spaces.
  - **Referrals to GBV Services:** When referring to GBV services, it is important to emphasize the additional support a survivor can receive for her own wellbeing. This includes ensuring she is safe

<sup>26</sup> Bragg, 2003.

<sup>27</sup> *Ibid.*

and that she has access to relevant and confidential support and resources such as life skills resources and opportunities to connect with other supportive women.

- ☑ **Potential risks associated with receiving or not receiving referral services.** When discussing risks, it is important for the caseworker to get a sense of how the survivor/caregiver/child(ren) perceives the risks, ways in which s/he can manage the risks, and options for support if the referral is declined. It is important to note that in cases in which a child is being severely harmed or at risk of being severely harmed, the caseworker IS mandated to act in the best interest of the child by involving Child Protection staff without the survivor's consent.

- **Child Protection Services:** When a survivor accesses CP services for her children, it is important that she is assisted in understanding the nature of mandated reporting and services, the possibility of an assessment of care arrangements related to the child's safety, the potential involvement of the survivor's abusive partner in CP services, and the involvement of additional providers in her life, which could impact her safety.
- **GBV Services:** When a survivor accesses GBV services, it is important that she is assisted in understanding the services available, the nature of mandated reporting and services, including the confidentiality and privacy of GBV services and the stipulation that GBV services will not work with her abusive partner or children.

Once a referral is accepted, the caseworker will need to obtain consent/assent from the survivor and/or child(ren) to make the referral and to share information with the referral organization. As referenced in the Interagency GBV Case Management Guidelines, obtaining consent includes getting the survivor's permission to share information with other providers. This includes what information will be shared, when, with whom, and how the information will be shared (i.e., verbally, electronically, or through a paper system). As referenced in the CP Case Management Guidelines, consent/assent should also be obtained from children when referrals are being made on their behalf. When obtaining consent to share information, caseworkers will want to explain the reason for the caseworker wanting to have regular ongoing contact with caseworkers and direct service providers from other organizations. These reasons can include coordinating services to minimize duplicative efforts and conflicting appointments or information, and increasing the safety of both the family and the caseworkers involved in the case so as not to put anyone at heightened risk of violence. At times, these reasons may be helpful to share with other service providers as well, so as to ensure there is a mutual understanding of the purpose of collaboration and information sharing.

Discussions with survivors and children regarding referrals should also include:

☑ **How to get to the referral organization:**

- Physical location of the services
- Transportation options and support, including affordability and accessibility
- Options for the caseworker to accompany the survivor/child(ren) to the initial meeting

☑ **Who to see and what is likely to happen:**

- Giving the survivor/child(ren) the name of a contact person, if possible
- Doing intake and ensuring informed consent to receive services

☑ **The process of follow-up after their initial appointment**

- Discussing how the referring caseworker will maintain contact with the survivor/child(ren) and referral partner
- Scheduling a follow-up appointment to evaluate the success of the referral

Referrals to partners should be thorough and contain enough information for the organization to initially deem if the survivor/child(ren) is an appropriate fit for their services. The [Inter-Agency Referral Template](#) can be used as a template upon which to build referral forms for partner agencies if those forms don't already exist. Of particular importance to make note of when working with survivors of co-occurring IPV and child maltreatment is safety-related information, such as restrictions on when or how to contact the survivor. For example, referring providers should note whether it is safe to leave messages on the phone number provided, what to say if someone else answers the phone (you are calling about the child's school, etc.), or any limitations on home visits.

Both partner organizations should have open channels of communication for case coordination and feedback (see [Chapter 5](#) for case conferencing guidance). For example, there should be clearly outlined expectations as to how much information is shared, and how frequently the referral organization shares information with the referring organization, all of which the survivor/child(ren) have consented to. Additionally, feedback should be shared regarding the appropriateness of referrals and any issues regarding the need for referral, timing of referral, speed of response, or information sent. This will assist both organizations in improving service coordination in the future.

## SECTION B

### COMMON DILEMMAS

#### ❶ As a GBV caseworker, what should I do if I am concerned about a child's wellbeing, but a survivor doesn't want CP case management services?

In cases in which the child is in immediate life-threatening harm, GBV caseworkers should consult with a CP caseworker and request to have a joint conversation with the survivor so that she better understands what a referral entails and can discuss her fear, concerns, and questions about likely outcomes.

If the survivor still does not want to pursue services for her child, the GBV caseworker should immediately meet with their supervisors and discuss the case with colleagues from CP to assess their capacity to take on the child's case. As service providers, we have a duty to act on behalf of children, in the interest of their safety, even if those actions may directly contradict the wishes of their caregiver. In such cases, we should always have a conversation with the survivor about the fact that we will be pursuing support without her consent.

In these instances, there may be concern for the *survivor's* safety, and also her child(ren)'s, due to the fact that involving other service providers will expose to the abuser that she has sought help for the abuse and will therefore increase her and her children's risk. See [Chapter 4](#) for more information around safety planning and safely working across sectors.

As referenced earlier, in cases in which the child is not in immediate harm, GBV caseworkers may present the following options to adult survivors and ensure that the child receives a referral for care/support:

- GBV caseworkers may refer the survivor/child(ren) to CP case management workers practicing locally. In this case, the GBV caseworker should brief the survivor of what to expect through the referral process, including mandatory reporting laws for child maltreatment and the possibility of an assessment of care arrangements related to the child's safety.
- Children may access child-friendly safe spaces or other peer-group activities, as available and relevant.
- Adolescents may access safe spaces, job training/leadership development programs, as available and relevant.

- Children may access specialized psychosocial interventions, including trauma-informed healing, as available and relevant to the individual situation.<sup>28</sup>

### **② As a CP caseworker, what should I do if IPV is disclosed but the survivor doesn't want GBV case management services?**

The CP caseworker must respect the survivor's decision not to seek services. They can explore other options for services outside of traditional GBV case management. For example:

- Mothers may access women's safe spaces or other peer-group activities.
- Mothers and/or fathers may access job training/leadership development programs.
- Mothers and/or fathers may access specialized psychosocial interventions, including trauma-informed healing, as available and relevant to the individual situation.

### **③ What should happen when there is disagreement between sectors? For example, a CP caseworker would like to engage with a child, but the GBV caseworker feels CP engagement will cause harm to the child's female caregiver who is a survivor of IPV.**

A case conference should be called with both CP and GBV caseworkers and their supervisors to discuss and resolve differing opinions. For more on case conferencing see [Chapter 5](#). The conference discussion should be guided by prioritizing the safety of the child(ren) and the survivor and the *do no harm* principle. Discussion points include:

- What are the needs and desires of the survivor and child(ren)?
- What are the safety implications for the IPV survivor if her child(ren) is/are engaged in CP services? If they are not engaged?
- What are the safety implications for the child(ren) if they are engaged in CP services? If they are not engaged?
- What are the short- and long-term effects of engagement and the short- and long-term effects of no engagement on the survivor and child(ren)?
- Is there an option for the survivor and the child(ren) to both receive services?
- Is the physical and/or emotional harm to the child greater if the child is not engaged in CP services or if the child is engaged in CP services?
- What does/do the child(ren) want? What does the survivor want?
- Is there a way to sequence the services so that a survivor receives support from the GBV program first and perhaps stabilizes her situation and the GBV caseworker continues to raise the prospect of a CP referral once more trust and safety has been established?

The best interests of the guides decision making. For additional guidance and resources, please refer to the [Child Protection Case Management Guidelines](#) and the [Best Interest Determination Guidelines](#).

<sup>28</sup> International Rescue Committee, 2017.

## **④ How should we work with children and survivors when the other sector is not functioning or when case management isn't available?**

### **When there are GBV case management services but no CP case management services**

- ☑ Reach out to your GBV Technical Advisor who can consult with a CP Technical Advisor.
- ☑ As always, if the survivor is the non-abusive caregiver, work with her to safety plan for the child(ren). See [Chapter 4, Section C](#) on safety planning for more guidance.
- ☑ If the survivor is an abusive caregiver, provide additional support to her through modeling parenting skills and offering strategies for behavior management, if possible and appropriate.
- ☑ If the lives of children are at risk, involve appropriate state, government, or other protection actors to intervene when the child is at risk of severe harm. It is important to let both the survivor and her child(ren), if developmentally appropriate, know first before involving state, government, or other protection actors.
- ☑ See if there are any child or adolescent safe spaces that children can be encouraged to attend.

### **When there are CP case management services but no GBV case management services**

- ☑ Reach out to your CP Technical Advisor who can consult with a GBV Technical Advisor.
- ☑ Work with the survivor to safety plan for herself and her child. See [Chapter 4, Section C](#) on safety planning for more guidance.
- ☑ Ensure you are checking in regularly with the survivor regarding her assessment of her safety in relation to the CP case management plan. Make adjustments to the case management plan as necessary to ensure that her safety, her child(ren)'s safety, and the caseworker's safety is maximized.
- ☑ See if there are local women's organizations you can connect her with. They may not offer GBV response services but may provide a networking opportunity for her to seek help within a network of women.

## **⑤ How should collaboration be approached if both CP and GBV are already working with a family and don't know of the other sector's involvement?**

As a part of assessment in any case, the caseworker should inquire about any services the family may be receiving through other providers as a proactive measure to prevent both sectors from unwittingly working with the same family. If a child or caregiver informs a caseworker of another caseworker's involvement with the family, the caseworker receiving this information is responsible for obtaining consent from the survivor/caregiver to speak with the other caseworker to coordinate services. From this point, collaborative case planning should proceed as outlined in the guidance.

### ③ Are there interventions with the abuser that can jeopardize the safety of the survivor and her children?

The following interventions are **not** recommended when there is co-occurring IPV and child maltreatment:

- ✗ Couples or family counseling
- ✗ Mediation
- ✗ Speaking to the abusive partner on behalf of the survivor
- ✗ Any intervention the survivor feels jeopardizes her safety or that of her children

Participation in these types of services can increase risks for IPV survivors and their children. Couples counseling and mediation is based on the assumption that partners who possess equal amounts of power can negotiate a resolution. In abusive relationships, however, there is an unequal balance of power between survivors and abusers as well as a risk of physical violence or coercive attacks when the abuser feels challenged.

### ⑦ How should caseworkers respond to co-occurrence if the female caregiver/survivor is a child who is in an early/forced marriage?

Girl children who are in early/forced marriages are often given adult responsibilities and socially expected to take on an adult role both in family and community life. They are also often mothers with full parental rights in addition to still being both developmentally and legally children themselves. And yet, depending on the girl's age she does not have the maturity to be able to assess and make decisions in the same way as an adult woman can. Caseworkers should use a *survivor-centered approach* that is informed by an assessment of the girl's best interests; it is not suggested to enroll the survivor in child-centered activities because she may not be welcome there given her status as a wife and mother. For further guidance regarding assessing with the girl whether she would like to stay in the marriage/relationship, conducting a risk assessment and/or taking actions to help the girl leave her situation, please refer to Part III, Chapter 3 of the [GBV Case Management Guidelines](#).

## 4. Collaboration for Co-Occurrence

Once a referral is accepted between GBV and CP programs, the two service providers/caseworkers need to establish regular methods of working with each other and a shared agreement around roles and decisions regarding the case that need to be taken as a group. (See [Chapter 5](#) for further guidance around scheduling case conferences.)

Additionally, GBV and CP caseworkers should work together to facilitate streamlining of the family's access to services. When it is possible, both providers should plan to meet with the female caregiver and/or her children at the same time. For example, both caseworkers could meet with the survivor and her children at a women's safe space concurrently or consecutively.

Below, you will find further guidance on specific topics for collaboration.

### SECTION A

## CONFIDENTIALITY, MANDATORY REPORTING, INFORMATION MANAGEMENT, & SHARING

### Confidentiality

Confidentiality refers to the right of a person to have any information about them treated with respect. It promotes safety, trust, and empowerment. Confidentiality reflects the belief that people have the right to choose to whom they will, or will not, tell their story. Maintaining confidentiality means not disclosing any information at any time to any party without the informed consent of the person concerned.<sup>29</sup>

In GBV case management, confidentiality is maintained through strict information and data sharing practices that rest on principles of sharing only the information that is absolutely necessary to those involved in the survivor's care, and only with the survivor's permission. Allowing the survivor to make decisions regarding who knows about her case and how much they know gives her power and control over her life. In the case of a survivor of IPV, breaching confidentiality can put her, her children, and others at risk of further harm. Additionally, if helpers do not respect confidentiality, other survivors will be discouraged from coming forward for help.<sup>30</sup>

In child protection case management, confidentiality is linked to sharing information on a need-to-know basis. The term "need-to-know" describes the limiting of information that is considered sensitive and sharing it only with those individuals who require the information in order to provide a service the child requires. Any sensitive and identifying information collected should only be shared on a need-to-know basis with as few individuals as possible and with the consent/assent of the child and her/his caregiver.<sup>31</sup>

While both GBV and CP programs will be working in collaboration on many cases of co-occurring IPV and child maltreatment, it does not mean that every detail of a case needs to be shared across teams. As an adult, the survivor reserves the right to decide to whom she will or will not tell her story.

<sup>29</sup> GBVIMS Steering Committee, 2017.

<sup>30</sup> *Ibid.*

<sup>31</sup> Global Child Protection Working Group, 2014.

## Mandatory Reporting

Importantly, confidentiality is limited when caseworkers identify life-threatening safety concerns and need to reach out to other service providers for assistance or where they are required by law to report crimes.<sup>32</sup> Many countries have laws that require service providers to report to police or other government authorities any acts that are believed to be criminal offences and/or imminent threats to the safety of a child or other vulnerable individuals, including survivors of IPV. In most settings, mandatory reporting includes the intent to commit suicide, homicide, and severe harm to a child, and so the act of breaking confidentiality is done to protect those who may be at risk of severe harm. In addition, in humanitarian settings, all organizations are mandated to have policies and protocols in place (such as child safeguarding policies) for responding to sexual exploitation and abuse of children and adults by humanitarian workers; these policies should also include protocols for responding to known maltreatment of children by community or family members.<sup>33</sup> These limits must be explained to children, caregivers, and survivors during the informed consent or assent processes. Supervisors and caseworkers should work together closely to make decisions in such cases where confidentiality needs to be broken.<sup>34</sup>

Procedures are not the same for all mandatory reporting requirements, so it is important that your organization outline its mandatory reporting procedures.<sup>35</sup>

In some settings, particularly humanitarian settings, there are situations where, technically, a mandatory reporting law exists, yet the security situation is extremely unstable and/or dangerous and following the legal requirements for reporting could actually put a child or survivor at further risk of harm.<sup>36</sup> Additionally, while mandatory reporting is often intended to protect GBV survivors and children, in some cases following mandatory reporting procedures conflicts with the guiding principles for working with survivors and children, including confidentiality and self-determination.<sup>37</sup>

In such situations, the best interests of the child and survivor must be the primary consideration. For example, mandatory reporting of cases of sexual violence or intimate partner violence to the police can put the child or survivor at great risk of harm from the abuser, family members, or community members. Every organization must decide how they are going to handle mandatory reporting when it is not in the best interest of the survivor/child, including the protocols for reporting.<sup>38</sup>

## Informed Consent and Information Management & Sharing

Informed consent is the voluntary agreement of an individual who has the capacity to give consent, and who exercises free and informed choice. Informed assent is the expressed willingness to participate in services and is often used for children and individuals who do not have the capacity (due to their developmental stage and/or age) to give consent.<sup>39</sup> Obtaining informed consent/assent is an important step in the process of engaging individuals in services. Informed consent allows for individuals to make a decision to receive services after understanding the full risks and benefits of doing so. Informed consent should be obtained when services are initiated, before making referrals, and before caseworkers take any actions, such as advocacy or case coordination, on behalf of an individual. For further guidance on obtaining consent and assent, reference the [Caring for Child Survivors of Sexual Abuse](#) guidelines.

<sup>32</sup> Global Child Protection Working Group, 2014.

<sup>33</sup> GBVIMS Steering Committee, 2017.

<sup>34</sup> Global Child Protection Working Group, 2014.

<sup>35</sup> GBVIMS Steering Committee, 2017.

<sup>36</sup> Global Child Protection Working Group, 2014.

<sup>37</sup> GBVIMS Steering Committee, 2017.

<sup>38</sup> *Ibid.*; Global Child Protection Working Group, 2014.

<sup>39</sup> Global Child Protection Working Group, 2014.

For agencies and caseworkers involved in case management, confidentiality also means collecting, keeping, sharing, and storing information on individual cases in a safe way and sharing only what is absolutely necessary to those involved in the survivor or child's care with the survivor's permission and on a need-to-know basis only. Both sectors should follow established guidance regarding the recording and storage of identifying and personal information. This includes avoiding informal conversations with colleagues who may be naturally curious about and interested in the work.<sup>40</sup> In order to share information with other departments within the same organization, other organizations or other partners, caseworkers must obtain consent from the survivor and/or child to share the information. This includes what information will be shared, with whom and a date by which that consent expires.

- When CP and GBV caseworkers are already collaborating around co-occurrence, information should be shared between CP and GBV caseworkers who are supporting the same family on a regular basis, depending on level of care and need. The GBV program can share information with the CP program regarding safety planning, safety concerns, and any services relevant to the children. CP service providers can share information with GBV service providers regarding child wellbeing, safety concerns, and any services related to the caregivers, especially any CP involvement with the abusive caregiver. While sharing information between caseworkers is an important part of the case management process and should include regular conversations with the survivor and child about the information that is being shared, caseworkers should take care to not become "messengers" for the survivor and child to communicate all information regarding services.

Cases of co-occurring IPV and child maltreatment should be recorded as their own incidents in GBV, and Child Protection information management systems as would be done for any GBV or CP case. The reason for this is that while the cases are occurring in the same family, they are ultimately different cases with some variations in risks, their own unique needs, and accessing different services. However, it is important to have some idea of the number of co-occurrence cases that your organization has managed over a given time period. As such, you may use the co-occurrence case notation form in [Annex 5](#).

Information-sharing at cluster level or with any other actors requires an information-sharing protocol is established. Information-sharing related to incidents of violence should ONLY include anonymized, aggregate trends. If you need to create an information-sharing protocol related to co-occurrence, please reach out to GBV and Child Protection advisors for further discussion.

## SECTION B

# CASE CONSULTATION

## A. Definitions, Purpose, & Goals of the Case Consultation

**Definition:** A case consultation is a process in which one staff member seeks out support and guidance from another caseworker and/or supervisor for support related to their specialized knowledge and skills. This often occurs between two teams that have differing areas of expertise, such as GBV and CP, and can occur in-person or remotely. The amount of detail shared in consultation is minimal, which includes not divulging any personal or identifying information so as to maintain confidentiality.

**Purpose:** Case consultations form the basis of collaboration between CP and GBV when co-occurrence is identified. They are often initiated by a caseworker and/or their supervisor to seek out support and guidance from another provider on a particular situation. These meetings are often scheduled as needed to discuss best practices in approaching an unidentified case.

**Participants:** Participants in the case consultation should include the caseworker supporting the child survivor, the supervisor, and at least one caseworker or casework supervisor from the other sector. There

<sup>40</sup> GBVIMS Steering Committee, 2017; Global Child Protection Working Group, 2014.

should NOT be any individuals invited to or present for the consultation whose input would not be relevant to the case.

## B. Case Consultation Process

The case consultation discussion is informal in nature and should happen when a case issue is identified. The discussion should include a brief overview of the case and challenges/reasons for requesting the guidance and support of colleagues. The case being discussed should not be linked with any individuals and should be talked about in general terms (i.e., using the terms “the child” or “the female caregiver,” rather than names or other identifiers). The group should brainstorm ways to address the issues that were identified. This can include:

- Determining ways to move forward to best support the child and/or survivor
- Weighing pros and cons for any proposed actions or interventions
- Ensuring the child and caregiver(s)’ wishes are taken into account and weighed against the child’s best interests
- Considering the issues around safety for any proposed next steps
- Listing potential positive and negative effects of each service option and whether or not they are appropriate given the nature of the co-occurring violence.

The discussion should end with participants verbally agreeing on which options to pursue in response to the needs and issues identified.

## SECTION C

### SAFETY PLANNING FOR CO-OCCURRENCE

One of the main ways in which approaches to services differ between CP and GBV sectors is whose safety is prioritized. Rightfully so and in line with each sector’s population, CP actors prioritize children’s safety and GBV actors prioritize women/survivor’s safety.<sup>41</sup> At times, this leads to misconceptions and mistrust of both sectors; CP actors may feel that GBV actors, by focusing on the survivor (who may also be abusive or neglectful toward the children), are deprioritizing the needs of children, whereas GBV actors may feel that CP actors revictimize survivors by placing responsibility and blame on them for the behaviors of their abuser.<sup>42</sup>

Safety planning in situations of co-occurrence can be complicated due to the different approaches that CP and GBV actors use in their case management services. For example, CP actors, in most instances, will engage with both caregivers – the survivor and the abuser – in efforts to create healthy and stable families.<sup>43</sup> However, this is often in conflict with GBV actors, who, as a matter of safety, do not engage with abusers. For these reasons, among others, it is imperative that both CP and GBV providers pay close attention to and account for safety in their work with families in which there is co-occurring IPV and child maltreatment. For a sample safety plan document, refer to [Annex 6](#).

<sup>41</sup> Bacchus et al., 2017.

<sup>42</sup> Bragg, 2003.

<sup>43</sup> *Ibid.*

## Joint Safety Planning

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One of the key interventions in GBV case management is the creation of a safety plan with survivors. The safety plan enables the survivor to think through a pre-determined course of action when she is in a life-threatening situation.<sup>44</sup> Safety plans are meant to help a survivor tap into her existing intuition, resources, and strategies to maximize her safety and that of her children when they are in danger. Safety plans are not meant to assign responsibility to the survivor for the violence she experiences nor are they meant to imply that the survivor has control over the actions of her abuser.

When supporting families with co-occurring IPV and child maltreatment, it is best practice to work with the survivor/female caregiver and child(ren) together to develop a joint safety plan. CP and GBV caseworkers should collaborate in safety planning with survivors and children to incorporate their expertise in safety plan recommendations. It is important for both CP and GBV caseworkers to recognize that the survivor and child(ren) know the patterns of behavior in the household best and they are integral in developing a safety plan that is effective.<sup>45</sup> Safety planning with children often depends on the child's age and circumstances – some children feel that developing a safety plan helps them feel safer and can provide life-saving strategies, while others need to know that their caregivers can protect them; regardless, it is important to explore developmentally and age appropriate strategies with children, strategies that they can use to stay safe.<sup>46</sup> CP caseworkers, in partnership with GBV caseworkers and caregivers, should review and practice the safety plan steps with children. This could happen in many ways, depending on the situation; for example, the CP caseworker and GBV caseworker could share the safety plan with each other, and the CP caseworker could then review the safety plan with the child(ren) and caregiver or both caseworkers could meet with the child(ren) and caregiver to review the safety plan as a group.

In addition to the safety plan outlined for the survivor, in cases of co-occurring IPV and child maltreatment, the following actions may be discussed in a child-focused and age-appropriate format:

- ☒ Agreeing with children when and who to contact for help
- ☒ Deciding with children when to leave the home as things begin to escalate, and where to go
- ☒ Identifying a code word to say in case of an emergency
- ☒ Identifying a safe space the children can go to in the home and something to think about when they're afraid
- ☒ Teaching children that they should never intervene, even though they may wish to do so
- ☒ Helping children make a list of people with whom they are comfortable talking<sup>47</sup>
- ☒ Exploring the mother and children's further engagement with adults whom the children identify as safe and supportive, such as teachers, relatives, mentors, etc.<sup>48</sup>
- ☒ Identifying a place for children to go in an emergency and the steps to take to find safety<sup>49</sup>

Once a safety plan is developed, it is important for CP and GBV providers to review, reassess and revise the plan with the survivor/child(ren) on a regular basis. Operationally, this can look different depending on the situation; for example, the CP caseworker can review the safety plan with the child(ren) while the GBV caseworker reviews the plan with the survivor, or both CP and GBV caseworkers can meet with child(ren) and survivor to review the safety plan as a group. How the safety plan review occurs is based on the survivor/child(ren)'s preference and the feasibility of joint meetings.

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<sup>44</sup> GBVIMS Steering Committee, 2017.

<sup>45</sup> Bragg, 2003.

<sup>46</sup> *Ibid.*

<sup>47</sup> The National Domestic Violence Hotline.

<sup>48</sup> International Rescue Committee, 2017.

<sup>49</sup> Bragg, 2003.

After careful consideration, survivors and children will decide whether to use, adapt, replace, or discard certain approaches, given the risks they believe it will pose to them. For example, many survivors may act in ways that seem contradictory to their desire for safety; however, those actions are carefully calculated and executed. Examples of such protective strategies survivors use include:

- Complying, placating, or colluding with the abuser
- Minimizing, denying, or refusing to talk about the abuse for fear of making it worse
- Leaving or staying in the relationship so the violence does not escalate
- Fighting back or defying the abuser
- Sending the children to a neighbor or family member's home
- Avoiding violence through misinformation or withholding the truth from service providers
- Refusing or not following through with services to avoid angering the abuser
- Using or abusing substances as an "escape" or to numb physical pain
- Lying about the abuser's maltreatment of the children to avoid further violence towards the children
- Trying to improve the relationship or finding help for the abuser.<sup>50</sup>

It is important that caseworkers not immediately label these behaviors and actions as dangerous, noncompliant, or maladaptive without working with the survivor to understand her decision-making process and reasons for her actions.

For a sample joint safety plan, see [Annex 6](#). For more guidance on safety planning for survivors, see the [GBV Case Management Guidelines](#).

### Caseworker's Role and Safety

As mentioned above, GBV programs do not engage with abusers; however, it is common practice for CP providers to engage with and provide services to both caregivers in a household, including the abuser, in an effort to provide services and ensure the wellbeing of the child. This can pose a threat to the survivor's safety and that of the caseworker.

When working with both caregivers in instances of co-occurrence, it is imperative that the CP caseworker engage with both the GBV caseworker and the survivor to ensure the interaction and support to the caregivers does not put the survivor nor the children at increased risk of violence. Furthermore, when caseworkers make decisions without the survivor's input, this may mirror the abuser's behavior in that it dictates control over choices. CP caseworkers can empower survivors by allowing them to make informed decisions regarding safe alternatives and services that will enhance their children's safety, even if CP is engaging with the abusive caregiver.<sup>51</sup>

As mentioned earlier, CP caseworkers often provide services to families in their home. This approach to service provision may put CP caseworkers, children, and survivors at increased risk of harm in cases of co-occurring IPV and child maltreatment. It is important for CP caseworkers to work with their supervisor, the GBV caseworker involved in the case (when applicable), and the survivor to determine if it is safe for the CP caseworker to conduct home visits. Such discussions are best placed in the context of a case conference or a meeting in which both CP and GBV caseworkers are present with the survivor and any other applicable supports. In many circumstances, this decision can and should be made at the coordinator or manager level.

<sup>50</sup> *Ibid.*

<sup>51</sup> Bragg, 2003.

### Steps to take to evaluate CP caseworker safety:

- ☑ Assess the risk to all parties involved by conducting or not conducting home visits.
- ☑ If the risk is deemed to be too high for the caseworker to conduct home visits, develop a plan for an alternative safe meeting location in which services can be delivered.
- ☑ Establish a signal with the child and/or survivor for when a home visit is not safe. For example, this could include the child or caregiver reciting a pre-determined phrase or putting a particular household item or piece of clothing outside the home.
- ☑ Involve the family in group activities as well as case management to normalize their involvement with the family.
- ☑ Potentially institute a policy in which caseworkers do not go on home visits alone.
- ☑ Establish policies for caseworkers to check-in with supervisors when on home visits.
- ☑ Develop a caseworker safety plan.
- ☑ Ensure staff have access to resources, such as designated work (not personal) cell phones and security assistance, if possible.

To maintain the safety of the survivor and the children, it is important that caseworkers DO NOT engage in IPV mediation with the caregivers. This includes talking about IPV with the abusive caregiver alone or with the survivor, even if the survivor asks for this to be done.

## 5. Case Conferencing for Co-Occurrence

### SECTION A

#### DEFINITIONS, PURPOSE, & GOALS OF THE CASE CONFERENCE

**Definition:** A case conference is a planned and structured meeting with multi-disciplinary participants organized to discuss and coordinate services for a shared case.<sup>52</sup>

**Purpose:** Case conferences are often called for and planned by a caseworker and/or their supervisor to allow the time and space for multiple service providers to come together to develop or review a case plan for a complex or high-risk case that they are supporting.<sup>53</sup> These meetings are often scheduled when a client's needs are not being met, to identify or clarify ongoing coordination issues, and/or to provide a client with more holistic, coordinated, and integrated services.<sup>54</sup>

For co-occurring IPV and child maltreatment, case conferences should be called when any major family crisis occurs or action is being undertaken, for example:

- ☑ Violent incident in the home from which there were serious injuries (survivor/child[ren])
- ☑ Potential removal of a child from the home
- ☑ Survivor deciding to leave her abusive partner

**Participants:** Participants in the case conference will differ depending on the case, but all case conferences should be attended by the caseworker, the caseworker's supervisor, and at least one caseworker or casework supervisor from each of the other organizations providing services to the survivor/child(ren). There should NOT be any individuals invited to or present for the conference that are not directly involved in the family's case.

In some circumstances, the survivor/child(ren) may be invited to attend the conference if it is deemed appropriate. Regardless, the perspective of the survivor/child(ren) should always be considered and incorporated during a case conference. In cases of co-occurring IPV and child maltreatment, the abusive partner (male caregiver) should **NOT** be invited to or involved in the case conference.

### SECTION B

#### CASE CONFERENCE PROCESS

1. **Preparation:** This step is integral to the success of the case conference because it sets the foundation for a structured and informed conference. This step occurs before the case conference and is usually completed by the organization requesting the conference. In some instances, case summaries are shared in advance, following the principles of confidentiality. Preparation should include:
  - a. Ensuring that there is a release of information from the caregiver and child, as applicable, on record giving the involved organizations permission to discuss the case.

<sup>52</sup> Interagency CP CM Coaching Programme; Comprehensive Coordination Support to Child and Adolescent Survivors of Sexual Abuse in Emergencies Initiative.

<sup>53</sup> Interagency CP CM Coaching Programme.

<sup>54</sup> GBVIMS Steering Committee, 2017.

- b. Discussion and preparation of a summary of the presenting issues for the survivor/child(ren) (i.e., a summary of the current situation and most pressing needs as identified by the survivor, child, and service providers involved).
  - c. Preparation of a summary of the original protection needs (i.e., the reason the survivor/child began working with each organization).
  - d. Preparation of a summary of any immediate safety and/or risk concerns (i.e., escalating violence in the home, alternative care options for a child[ren], etc.)
  - e. Determining and sharing the location, date, and time with all involved parties.
2. **Starting the Conference:** The meeting should begin with introductions, a summary of the purpose of the meeting (to review and revise the service plan and to ensure the survivor/child[ren] are safe and well), and to go over ground rules. There should be one facilitator (usually a supervisor) who is responsible for adhering to the agenda and ensuring everyone participates. Some ground rules can include:
- a. **Confidentiality:** The information shared within the meeting should not be shared with anyone outside the meeting, within the confines of local mandated reporting requirements (i.e., reporting child abuse/neglect, suicidality, etc.). If the survivor and child(ren) are not present for the conference, the participants should agree to share the action plan and a summary of the discussion points with the survivor/child(ren).
  - b. **Respect:** One person should speak at a time, and everyone should listen respectfully to each other's ideas, opinions, and thoughts. Every participant will have the opportunity to speak and ask questions. The facilitator will be responsible for keeping the conversation on topic and may need to stop or otherwise interrupt participants to facilitate the conference.
  - c. **Shared Responsibility:** Everyone in the room shares the responsibility of supporting the survivor/child(ren) to reach the best, safest, and most appropriate outcomes. At times, this shared goal and responsibility can be lost in discussions about approach and organizational mandates, especially when organizations have differing ways of working; however, it is important to remember that everyone present is working towards the same goal: child and caregiver wellness and safety.
3. **Case Discussion:**<sup>55</sup> The lead organization will then present the information compiled during the preparation phase and will ask for the other organizations to add in their updates, information, and thoughts on the case. While discussing the survivor/child(ren)'s situation, it is important to keep in mind:
- a. Challenges, risks, and safety concerns
  - b. Strengths, resiliencies, and resources
4. **Brainstorm Interventions:** Once the case is presented and discussed, the lead organization will work with the other providers to brainstorm ways to address the issues that are preventing the survivor/child(ren) from making progress towards achieving their case plan. It is important to list potential positive and negative effects of each service option and whether or not they are appropriate given the nature of the co-occurring violence.

<sup>55</sup> For additional information on case discussion, see the Case Discussion Tool from the [Case Management Supervision and Coaching Package](#).

5. **Update/Create Action Plan:** Participants agree on which options to pursue in response to the needs and issues identified. This includes which services will be provided, discussions that need to be held with the survivor/child(ren), and follow-up to be conducted by each organization. Each action will have a person/organization responsible and a deadline for completion. The lead organization will be responsible for following-up on each action point. If the parties involved cannot come to an agreement on next steps, technical staff and additional supervisors should be consulted within a specified timeline after which a decision will be made regarding next steps. The consultation and decision should be made and communicated by the lead organization within no more than three business days of the case conference.

## SECTION C

### DOCUMENTATION & FOLLOW-UP

The lead organization is responsible for documenting the case conference. Detailed notes should be taken by someone other than the lead facilitator. After the conference, notes and the completed **Case Conference Documentation Form** should be shared with all applicable participants through password protected digital files.

## 6. Supervision<sup>56</sup>

Supervisors play an important role in supporting caseworkers' safe implementation of quality services and the regular ongoing development of productive collaboration between providers in different sectors. While supervisors should have ongoing and regular contact with each of the caseworkers they supervise to discuss difficult or complex cases, such as cases in which there is co-occurring IPV and child maltreatment, caseworkers should also proactively seek out supervisory support when there are safety concerns and concerns for which immediate action is needed. The following examples would fall into that category of needing immediate supervisory support:

- Cases in which a child or survivor is severely harmed and needs immediate medical or mental health care
- Cases in which the caseworker is concerned about her or his own safety in providing services, such as threats from abusive partners (in IPV) or situational violence
- Cases in which a child or survivor expresses that they are suicidal or will harm another individual

When examining the role supervisors play in ensuring best practices in case management for co-occurrence, it is helpful to look at the three functions of supervision: Administrative, Educational, and Supportive.<sup>57</sup> Below are explanations of each function in the context of co-occurrence (see the [Child Protection Case Management Supervision and Coaching package](#) for more information). When organizations and teams are just beginning to address co-occurring IPV and child maltreatment in an intentional manner, it can be helpful to have a supervisor model ways of working by taking on the case management of the first co-occurrence case in which there are collaborative efforts between GBV and CP teams.

### 1 ADMINISTRATIVE: Supporting Collaborative Relationships

Supervisors must encourage caseworkers to regularly partner with other service providers and sectors on assessment and intervention in cases of co-occurring IPV and child maltreatment. It is imperative that supervisors are knowledgeable about and enforce compliance with organizational procedures for co-occurrence so that they can help caseworkers integrate the specialized case practice guidelines in their assessments and interventions. Supervisors should continue to monitor and enforce compliance with this guidance to determine caseworker capability with cases involving co-occurrence.

### 2 EDUCATIONAL: Providing Oversight and Review of Appropriate CP and GBV Practices

Supervisors may need to provide additional guidance to caseworkers who are trying to make difficult decisions and recommendations that will not compromise the safety of survivors and children. Specialized policies or protocols as well as additional training for cases involving co-occurring IPV and child maltreatment can serve as supports for supervisors and caseworkers. Supervisors can also support caseworkers to seek out and develop professional coaching and mentoring relationships with colleagues from other sectors. This also includes educating caseworkers on the importance of both sectors (GBV and CP), checking for unhelpful biases and addressing gaps in technical knowledge or competencies. Supervisors who support caseworker participation in cross-training opportunities demonstrate their commitment to promoting competence in achieving safe outcomes for families.

<sup>56</sup> Bragg, 2003; Alliance for Child Protection in Humanitarian Action, 2018.

<sup>57</sup> Kadushin, 1992.

### ③ SUPPORTIVE: Creating Safe Spaces for Caseworkers to Reflect on Their Work

Working with families in which there are multiple forms of violence occurring is difficult and may cause stress and anxiety. It is important for supervisors to demonstrate that they are available to discuss staff wellbeing including maintaining safety, reinforcing realistic expectations and healthy boundaries, and promoting self-care.

Supervisors are also responsible for assessing the competencies and readiness of their staff to engage in work around co-occurrence. Please see [Annex 8](#) for a Co-Occurrence Case Management Reflection Tool for caseworkers to use after completion of a case can help illuminate areas in which caseworkers need additional support.

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## ANNEX 1

# Child-Centered Approach (CP)<sup>1</sup>

A child-centered approach places the child and his/her needs at the center of the case management response and guides any decisions made with and for the child. The aim of the child-centered approach is to support the child and ensure his/her rights are fully respected and upheld throughout the process. A child-centered approach recognizes that each child:

- Has equal rights to care and support
- Is different and unique
- Will react differently to their experience of violence, abuse, neglect, and exploitation
- Has different strengths, capacities, resources and needs that should be taken into consideration
- Has the right, appropriate to her/his age and circumstances, to decide who should know about what has happened to her/him and what should happen next
- Should be believed and be treated with respect, dignity, and empathy
- Child rights-based

When working with children, it is crucial that we approach the work and adapt the way we communicate and interact with the child in accordance with their age, developmental stage, gender, and ability. Using a child-centered approach means that you:

- **Promote the child's best interests at all times:** All decisions that are made with and for the child should be guided by the best interests of the child. This fundamental principle encompasses a child's physical and emotional safety (their well-being) as well as their right to positive development. The best interests of the child should provide the basis for all decisions and actions taken, and for the way in which service providers interact with children and their families. Children's best interests are analyzed throughout the case management process through a comprehensive assessment of all of the following:
  - Individual situation and experiences
  - Age/developmental needs
  - Gender
  - Level of maturity
  - Physical and psychosocial situation
  - Protection needs
  - Family situation
  - Strengths/resources
- **Evaluate the best course of action:** Caseworkers and their supervisors must constantly evaluate the risks and resources of the child and her/his environment as well as positive and negative consequences of actions together with the child and their caregivers when making decisions. All actions should ensure that the child's rights to safety and on-going development are never compromised. Often there is no one "ideal" solution possible, but rather a series of more or less acceptable choices that must be balanced with a child's best interests.
- **Encourage active participation of the child (and their caregivers where appropriate):** Caseworkers should ensure that children understand what is happening, understand the decision-making process, and are involved in the decision making. These need to be communicated to the child in a way and using language that they understand. For older adolescent girls and boys, caseworkers should support and guide them through the decision-making process, recognizing their developmental stage and taking into consideration their wishes and needs.

<sup>1</sup> Global Child Protection Working Group, 2014.

# Survivor-Centered Approach (GBV)<sup>1</sup>

A survivor-centered approach aims to create a supportive environment in which each survivor's rights are respected and in which the person is treated with dignity and respect. A survivor-centered approach recognizes that every survivor:

- Has equal rights to care and support
- Is different and unique
- Will react differently to their experience of GBV
- Has different strengths, capacities, resources and needs
- Has the right, and is best placed appropriate to her/his age and circumstances, to decide who should know about what has happened to her/him and what should happen next
- Should be believed and be treated with respect, kindness, and empathy.
- Deserves care that is grounded in the women's movement and feminist theory and practice

Using a survivor-centered approach means that you:

- **Validate the person's experience:** A survivor-centered approach emphasizes the importance of communicating to the survivor that we believe her/him and that we do not judge their experience or their decisions about what to do. We trust that they are the experts of their situation.
- **Seek to empower the person:** A survivor-centered approach puts the individual at the center of the helping process and aims to empower the person. We recognize that an experience of GBV may take away a person's control over their body and mind. Our interactions with a survivor should aim to restore their sense of control by making sure they are the decision-makers throughout the helping process.
- **Emphasize the person's strengths:** A survivor-centered approach recognizes that survivors have existing ways of coping and problem-solving. Understanding and building upon a survivor's inner and outer resources – for example, prior successes in managing the aftermath of or overcoming a stressful or traumatic event – is a great way to begin to shift the focus from their weaknesses and problems to their strengths. This strengths-based approach helps to build and recognize people's inherent resilience.
- **Value the helping relationship:** A survivor-centered approach emphasizes that a helper's relationship with a survivor is a starting point for healing. This means that we must view all of our encounters with a survivor as an opportunity to build connection and trust while establishing healthy professional boundaries.

<sup>1</sup> GBVIMS Steering Committee, 2017.

## ANNEX 3

# Complimentary Differences in Child and Survivor Centered Approaches

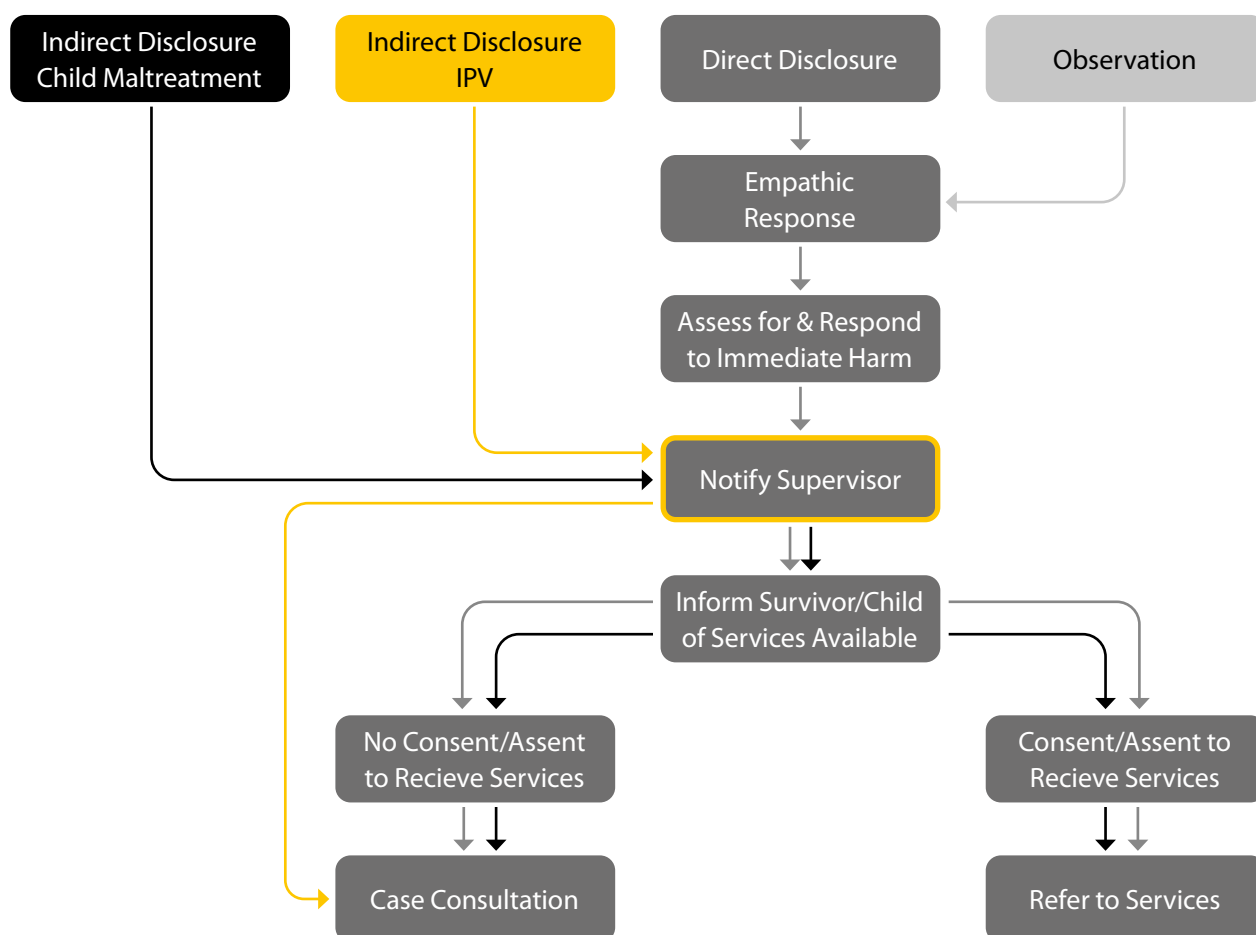
The differences seen across GBV, and CP approaches are best seen as complimentary differences in which combining the unique approaches leads to strong and well-rounded service provision in instances of co-occurring IPV and child maltreatment. These complimentary differences ultimately stem from the GBV survivor-centered approach and the CP child-centered approach. This is best illustrated in the initiation of services, the focus of initial services, different components of case planning, and in the physical spaces in which services are offered:

|                        | Child-Centered Approach (CP)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Survivor-Centered Approach (GBV)                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Decision Making        | In CP case management, the caseworker takes on some of the decision making themselves, and/or guides the decision making and the assessment of the child's situation to determine the best course of action, together with the child and their caregiver, guided by the best <i>interests of the child</i> . Decisions need to take into consideration all aspects of a child's situation, including the risks to the child, their caregiver and others and weigh these against the best interests of the child. | In GBV case management, the caseworker does not make any decisions for the survivor or her family. First and foremost, it is unsafe to make decisions on their behalf. The experience of GBV takes away a survivor's sense of control so GBV caseworkers aim to restore survivors' sense of control by making sure they are the decision makers. This includes supporting survivors even if caseworkers feel the decision they are making is not in their best interest.                                  |
| Initiation of Services | CP case management often begins with identification in which CP actors seek out children in need of protection, including accepting referrals from other sources, such as community members or service providers. This is because children, by virtue of their age, developmental capacity and standing in society, are often not able to or capable of reaching out on their own for protection.                                                                                                                | GBV case management begins with a survivor seeking out services for the violence she has experienced. This is because survivors have been victimized and controlled by their abusers, a pattern that service providers do not want to replicate by "identifying" survivors against their will or forcing survivors into services. This also helps reduce the risk of retaliatory violence from abusers if a provider were to "identify" the woman as a survivor (and therefore her partner as an abuser). |
| Focus of Services      | In CP case management, the focus of services is determined by taking into account the child's situation, individual characteristics (age, gender, disability status, developmental stage, strengths) and her/his experience of maltreatment to help determine the child and family's immediate and longer-term needs. This process usually involves multiple perspectives, including those of the child, caregivers and other "safe adults" in the child's life, as well as the caseworker's observations.       | In GBV case management, the focus of services is determined by the survivor's wishes and an assessment, which is often focused on the incident for which the survivor sought out services. GBV case management only involves other individuals at the request of the survivor. The survivor's multiple needs are taken into account and addressed through a variety of women-centered programming                                                                                                         |

|                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                         |
|---------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Components of Service/Action Planning | In CP case management, the child's wishes guide decision making, but ultimately, decisions are made with the child, non-offending caregiver(s), and caseworker in regard to the services s/he receives and are guided by the child's best interests. In certain contexts, when the child is at severe risk, it will be necessary for authorities such as state or international actors to make a formal decision according to the child's best interest. At times, decisions may involve alternative care systems through formal or informal channels. | In GBV case management, the survivor guides the case action plans and makes all decisions relating to her services. Additionally, work IPV with survivors always involves safety planning as an ongoing activity and service. Mediation is not recommended or undertaken in GBV case management due to unequal power dynamics of the relationship and the recognition that the caseworker supports the survivor of IPV. |
| Location of Services                  | In CP case management, caseworkers actively and regularly follow up the situation and meet with children and their families in the home, schools or in other spaces in the community where the child/family feel safe.                                                                                                                                                                                                                                                                                                                                 | In GBV case management, the survivor typically meets with a caseworker in a safe space or confidential room that is anonymous for safety reasons and rarely, if ever, meets with the caseworker in the home.                                                                                                                                                                                                            |

For more on home visits and safety, see **Section 4.B**

# Response Decision Tree





## ANNEX 6

# Sample Joint Safety Plan

**Directions:** Safety plans should be completed with a survivor and her children when they are at risk. The safety plan should be realistic, easy to remember, and based on the survivor and child(ren)'s situation. In most cases, there will be some questions below that are not applicable to the situation or that don't have clear answers – that is okay! Prioritize the questions that are most supportive of the survivor's safety and that of her children. Complete the safety plan in person in a private space with no one other than the survivor and her children. Information from the safety plan **must be kept confidential** and can only be shared if the survivor signs a release of information.

The safety plan should be recorded and kept in the survivor's confidential case file and a hard copy of it can be shared with the survivor and her children **if they feel having a copy of the plan with them will not put them at further risk**. The safety plan should be reviewed and revised regularly with the survivor and children. The numbered questions below are suggested questions that can help in identifying a safety plan; they correspond to each number of the safety plan on the following pages.

**Introduction Script:** *"It is important to know that [the perpetrator's] behavior is not your fault. While you are not responsible for their behavior, let's think about ways you can increase safety for you and your children and be prepared if there is an emergency. I will ask you questions to help you think about a plan. You can decide what will work best for you and your children. I will be here to support your decisions no matter what they are.*

*As always, everything you tell me is confidential. This means I will not tell anyone other than my supervisor (including anyone in your family) what you tell me unless you ask me to or unless it is information I need to share because you are in danger, or a child is in danger. I want you to know these limitations to our confidentiality so that I do not break your trust and so that you can make decisions about what you want to share with me based on these limitations. Do you have any questions?"*

## 1. What phone numbers do you need to memorize in case of emergency?

This can include safe emergency response services such as shelter providers, authorities, or people the survivor trusts.

## 2. Whom do you trust if you need help?

Think about anyone (neighbors, friends, family, or organizations) that the survivor can trust and how these people can help keep her safe. For example, discuss having a signal with helpful neighbors. Upon seeing this signal from the survivor, neighbors would plan to visit in a group. Survivors can also establish a code word to let someone know to call for help.

## 3. What community or faith leaders, members, or organizations might you involve?

Think about community or religious resources that might be involved in helping keep the survivor safe.

## 4. Are there specific signals or triggers that indicate [the perpetrator] may become more violent?

Identify triggers and ideas for avoiding these triggers if possible.

## 5. Where are potential weapons in your home? How can you protect yourself against potential weapons in the home (ex: knives, pans, sticks)?

If there are potential weapons in the house, the survivor should know where they are and try to guide any fights away from potentially dangerous areas (kitchen, bathroom, etc.).

## **6. What important documents do you have?**

This includes documents for the survivor and her children, including birth certificates, identification, passport, marriage certificate, and medical and school records. If the survivor does not have access to these documents, help the survivor brainstorm how to make copies and hide them. She may consider keeping copies with people she trusts. Caseworkers might also keep copies of important documents locked and confidential at the office.

## **7. How can you involve your children in planning for safety?**

The children should know not to try to stop the fighting and that the fighting is not their fault. The children should know how and when to call emergency services, if safe. The survivor should tell the children's school or daycare provider who is allowed to pick them up. If the survivor goes to a safe shelter, the children should know to keep their location a secret.

## **8. How will you know when you need to call authorities?**

It is best if the survivor decides on specific circumstances under which she would involve authorities, if at all. Make sure to discuss any barriers (access to a phone, language barrier, fear of consequences) so that the survivor feels capable of calling authorities if and when needed. You might role-play how this call might sound.

## **The following questions are for survivors who are considering leaving a violent setting or are ready to leave:**

---

### **9. If you are in danger and need to leave, is there a safe place you can go?**

Think about temporary and long-term options and review both benefits and risks. If the survivor plans to stay temporarily at someone else's house, discuss whether or not the perpetrator might come look for the survivor there and whether or not someone in the community may inform the perpetrator of the survivor's whereabouts.

### **10. If you need to leave, what will you take with you?**

Consider all important documents for the survivor and her children, as well as clothing, food, medication, and money. Include specific plans for how to transport the belongings and explain that survivors may not be able to return home to get their belongings if they enter a shelter.

### **11. If you need to leave, how will you do it?**

If the survivor drives, consider keeping gas in the car and extra copy of the keys in a secret location that is easily accessible. If the survivor does not drive, make a feasible transportation plan. This may involve friends or neighbors that the survivor trusts or keeping emergency transportation funds.

### **12. If you need to leave, what will happen to your children?**

If she has custody of the children, the survivor should make every effort to bring the children with her if she leaves so that the perpetrator cannot use the children to threaten the survivor. If not, where is a safe place for the children to go?

### **13. If you leave, will you need to do anything to protect your finances?**

Think about changing passwords or PIN numbers or changing/protecting bank accounts.

### **14. Who else might be in danger if you leave?**

The survivor may be hesitant to leave a dangerous situation because she is worried about consequences for others in her family or community. Help the survivor to prioritize her own safety.

**The following questions are for children and should include age and developmentally appropriate plans.**

**15. What phone numbers do you need to memorize in case of emergency?**

This can include safe emergency response services such as shelter providers, authorities, or people the survivor and children trust.

**16. Whom do you trust if you need help?**

Think about anyone (neighbors, friends, family, or organizations) that the child can trust and how these people can help keep them safe.

**17. Where is a safe place in the home?**

Think about a safe and comforting place in the home where the children can go if there is ongoing violence. Identify happy memories or a favorite story the children can think about while in that space. This can include bringing a favorite item such as a toy or belonging.

**18. Who is a safe person the children can talk to?**

This may be the same person as number 16 or others that are safe adults who know about the violence and are able to maintain confidentiality for both the survivor and children. This can include neighbors, relatives, teachers, and professionals.

**19. How can the children let safe adults know that something is wrong?**

Sometimes having a code word to share with safe adults can make verbalizing the need for help easier for children. Think of a word that is easy to remember, unique, and that won't often come up in everyday conversation for the children to use. Discuss when and how the code word can be used.

**20. Where is a safe place outside of the home for children to go if/when they are scared or in danger?**

This may be the same place/answer as number 9 but may also be with the safe adults listed in numbers 16 or 18. This includes what the children will tell those individuals when they get there and what they will tell other services/providers about their situation when they are in the safe place. For example, what will they tell their teachers if they are not staying in their home?

## CAREGIVER SAFETY PLAN

1. I will memorize these phone numbers to be prepared for emergencies:

2. If I need help, I can contact:

3. A community leader who can help is:

This is how they can help:

4. S/he is more violent when:

When I see these signs I can:

5. I can try to avoid potential weapons by:

6. These are the important documents I need to have:

I will keep copies:

7. I will tell my children:

*The violence is not their fault, and it is never right, even if someone they love is being violent.*

I will tell the school or daycare:

8. I will call authorities if:

9. If I need to leave, I can stay:

I will keep this location secret by:

10. If I need to leave, I will bring:

To make it easy to leave quickly, I will keep my things:

11. If I need to leave, this is how I will do it:

12. If I need to leave, my children will:

13. If I leave, I can protect my finances by:

14. Anything else I can do to increase safety:

## CHILD(REN) SAFETY PLAN

1. I will memorize these phone numbers to be prepared for emergencies:

2. If I need help, I can contact:

This is how they can help:

3. When I am scared, I can go here in the house:

When I'm there I can think about:

4. If I want to talk to someone, these are the people who can listen:

5. My code word is:

I can use my code word in these situations:

6. If I need to leave the home, I can go here

I will tell the school, daycare, or babysitter:

## ANNEX 7

# Case Conference Documentation Template

|                         |  |                     |  |
|-------------------------|--|---------------------|--|
| Case Number:            |  | Date of Conference: |  |
| Location of Conference: |  | Client Present:     |  |

## A. Pre-Conference Summary Review

|                                                        |  |
|--------------------------------------------------------|--|
| 1. Describe the presenting issues.                     |  |
| 2. Discuss the original protection needs.              |  |
| 3. Describe any immediate safety and/or risk concerns. |  |

## B. Conference Summary

### 1. Participant Summar

| Participant Name & Position | Organization | Contact Information |
|-----------------------------|--------------|---------------------|
|                             |              |                     |
|                             |              |                     |
|                             |              |                     |
|                             |              |                     |
|                             |              |                     |
|                             |              |                     |

2. Is there a signed release of information for all organizations present? ☐ Yes ☐ No

|                                                                                    |  |
|------------------------------------------------------------------------------------|--|
| 3. Purpose of case conference, including any additional updates from participants. |  |
| 4. Critical concerns identified at conference.                                     |  |
| 5. Strengths identified at conference.                                             |  |

## C. Action Plan

| Action | Person Responsible | Deadline |
|--------|--------------------|----------|
|        |                    |          |
|        |                    |          |
|        |                    |          |
|        |                    |          |
|        |                    |          |
|        |                    |          |

# Co-Occurrence Case Management Reflection Tool

**Purpose of the tool:** This tool was created to support GBV and CP caseworkers to reflect on their experience managing a case involving co-occurring IPV and child maltreatment after closing the case. It is designed to support deep reflection on the biases each individual may bring to this work and reflect on what went well and what could be improved in future cases. This tool may support a discussion with a case management supervisor and supportive supervision overall. It is not meant to be a tool for employee performance evaluation. Rather, the goal of this tool is to support case managers to think deeply about their work and how they can provide the best support to women survivors and children experiencing violence.

**Directions:** Before completing this tool, take a moment to recall the details of the case. How was it identified? What were the co-occurrence circumstances? How did the case consultation and any subsequent collaboration processes go? DO NOT record any written details here.

Date:

Caseworker name and title:

## Part 1: Attitudes for Co-Occurrence

|                                                                                                               | Strongly Agree | Agree | Disagree | Strongly Disagree |
|---------------------------------------------------------------------------------------------------------------|----------------|-------|----------|-------------------|
| Physical discipline is okay when used sparingly on children.                                                  |                |       |          |                   |
| It is okay for a husband to yell at and hit his wife if she doesn't think there's anything wrong with it.     |                |       |          |                   |
| IPV is never a child's fault.                                                                                 |                |       |          |                   |
| Children should be placed in alternative care if there is IPV in the home.                                    |                |       |          |                   |
| If an IPV survivor chooses to remain with the abuser, she is failing to protect her children from the abuser. |                |       |          |                   |

Notes:

## Part 2: Case Management and Collaboration

|                                                                                                                                                                                                                                                                                 | Agree | Disagree |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------|----------|
| <b>If there was a case consultation:</b> During the case consultation process, I respected confidentiality and did not share any identifying details of the woman or child I am supporting.                                                                                     |       |          |
| <b>If there was a case conference:</b> I was prepared for the case conference. This means I had all the necessary de-identifying details to discuss the case safely, had received consent to do so, and had prepared a summary of main protection concerns and immediate risks. |       |          |
| During case management, I considered how survivor-centered principles and the best interest of the child may align or differ based on the circumstances of the case.                                                                                                            |       |          |
| During case management, I considered how any actions I take may negatively affect the safety of the female survivor and/or child, and I discussed this with the collaborating caseworker.                                                                                       |       |          |
| I weighed the pros and cons of all service actions together with the collaborating caseworker.                                                                                                                                                                                  |       |          |
| I treated those who may have had a different viewpoint from my own with respect.                                                                                                                                                                                                |       |          |
| I successfully worked with my colleagues to brainstorm service options and come up with a plan.                                                                                                                                                                                 |       |          |

Notes:

## Part 3: Planning for Future Cases

One thing I did well in the case management process was...

Next time I manage a case of co-occurring IPV and child maltreatment, I would like to improve upon...

The part of the collaboration that went well was...

Collaboration between GBV and CP case managers could be improved by...