

INTER AGENCY GUIDELINES FOR CASE MANAGEMENT & CHILD PROTECTION



THE ROLE OF CASE MANAGEMENT IN THE PROTECTION OF CHILDREN:
A GUIDE FOR POLICY & PROGRAMME MANAGERS AND CASEWORKERS
JANUARY 2014



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FOREWORD

Anyone who has ever done case management knows what a complicated and often difficult task it is.

In regular situations this is already the case. In emergency situations - where levels of injury, physical violence, sexual violence, psychosocial distress, association with armed groups and separation are amplified - interventions are even more complex. The number of child protection cases is high, problems are multifaceted, social welfare staff is often overstretched and resources are more limited.

We know that a time-limited, hourly session with a child will not guarantee his/her protection. Careful assessment and support of (and for) family members and caregivers as well as liaison with community members, school personnel, court-related personnel, and child welfare agencies increases the likelihood that the child will remain safe and promote healthy relationships with others.

These guidelines have been developed at an inter-agency level to complement the agreed standard on Case Management (Minimum Standards for Child Protection in Humanitarian Action, 2012). They aim to provide a common understanding and step-by-step guidance on how to do case management. They put the child at the centre of the intervention, focusing on child friendly procedures and language.

I urge agencies working in the field of Child Protection in Emergencies to use and adhere to these guidelines in order to jointly provide the best possible support to the children that we serve.



Katy Barnett,
Coordinator Global Child Protection Working Group



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Special thanks also go to the European Community Humanitarian Office (ECHO) and the Office for US Foreign Disaster Assistance (OFDA) of the United States Agency for International Development for making the development of these guidelines possible.



GLOSSARY & WORKING DEFINITIONS

- Alternative Care:** *Alternative care is the care provided for children by caregivers who are not their biological parents. This care may take the form of informal or formal care. Alternative care may be kinship care; foster care; other forms of family-based or family-like care placements; residential care; supervised independent living arrangements for children.¹*
- Case Management:** *The process of helping individual children and families through direct social-work type support, and information management.*
- Caseworker:** *The key worker in a case who maintains responsibility for the child's care from identification to case closure*
- Child Protection:** *The prevention of and response to abuse, neglect, exploitation, and violence against children*
- Child Protection System:** *The set of laws, policies, regulations and services needed across all social sectors – especially social welfare, education, health, security and justice – to support prevention and protective responses inclusive of family strengthening”.²*
- Non-discrimination:** *The principle that distinctions should not be made between people or communities on any grounds of status, including age, gender, race, colour, ethnicity, national or social origin, sexual orientation, HIV status, language, religion, disability, health status, political or other opinion.*
- Protective factors:** *Conditions or attributes in individuals, families, communities, or the larger society that, when present, mitigate or eliminate risk in families and communities that, when present, increase the health and well-being of children and families.³*

1. Alternative Care in Emergency toolkit. Extended care guidance. Inter Agency Working Group on Unaccompanied and Separated Children
2. UNICEF Global Strategy, 2008.
3. Preventing Child Maltreatment and Promoting Well-Being: A Network for Action, Resource Guide. 2013

Psychosocial Support:	<i>Care and support which influences both the individual and the social environment in which people live and ranges from care and support offered by caregivers, family members, friends, neighbours, teachers, health workers, and community members on a daily basis but also extends to care and support offered by specialised.⁴</i>
Referral:	<i>The process of formally requesting services for a child or their family from another agency (e.g. cash assistance, health care, etc.) through an established procedure and/or form; caseworkers maintain overall responsibility for the case regardless of referrals.</i>
Resilience:	<i>The ability of children and their families to deal with, and recover from, adversity and crisis, influenced by individual characteristics and external factors like: diversity of livelihoods, coping mechanisms, life skills such as problem-solving, the ability to seek support, motivation, optimism, faith, perseverance and resourcefulness.</i>
Risk:	<i>The likelihood that a hazard will happen, its magnitude and its consequences; the probability of external and internal threats (e.g. armed attacks, natural disasters, gender-based violence) occurring in combination with individual vulnerabilities (e.g. poverty, disability, membership of a marginalized group)⁵</i>
Risk Assessment:	<i>Methodology to determine the nature and extent of risk by taking into account potential hazards and existing conditions of vulnerability that together could harm children and their families. Risk assessments should take into account community capacity to resist or recover from the hazard's impact.⁶</i>
Vulnerability:	<i>Physical, social, economic and environmental factors that increase the susceptibility of a community or individuals to difficulties and hazards and that put them at risk as a result of loss, damage, insecurity, suffering and death</i>

Organisations / Agency used interchangeably

In different settings people may use different terms such as “client” or “case” to refer to the individual at the centre of a case plan. As this guidance relates specifically to the management of child protection concerns, the term “child” is generally used.

4. Action for the Right of the child. ARC resource pack. 2009

5. Minimum Standards for Child Protection in Humanitarian Action, Child Protection Working Group, 2012

6. Ibid.

ACRONYMS AND ABBREVIATIONS

CM:	Case Management
CP:	Child protection
CPMS:	Child Protection Minimum Standards
CPWG:	Child Protection Working Group
ECHO:	European Community Humanitarian Aid Office
HIV:	Human Immunodeficiency Virus
IA CP IMS:	Inter Agency Child Protection Information Management System
IRC:	International Rescue Committee
MDG:	Multidisciplinary Group Meeting
NGO:	Non-Governmental Organization
OFDA:	Office of the US Foreign Disaster Assistance
Tdh:	Terre des Hommes
UASC:	Unaccompanied and Separated Children
UNCRC:	United Nations Convention of the Rights of the Child
UNHCR:	United Nations Commissioner for Refugees
UNICEF:	United Nations Children's Fund



INTRODUCTION TO THE GUIDELINES

BACKGROUND TO THE DEVELOPMENT OF THE GUIDELINES

The guidelines were developed in recognition of the increased emphasis and interest being placed upon case management as a service part of a child protection system. Case management is not new; however its application in humanitarian settings is relatively recent.

The intention in developing these guidelines was to provide a general framework of agreed principles, considerations, steps and procedures for effective child protection case management in line with the Minimum Standards for Child Protection in Humanitarian Action (CPMS)⁷ developed in 2012 by the Child Protection Working Group (CPWG). This is to provide interventions in line with Standard 15 of CPMS, which states:



Girls and boys with urgent child protection needs are identified and receive age- and culturally-appropriate information as well as an effective, multi-sectorial and child-friendly response from relevant providers working in a coordinated and accountable manner.

The primary focus of these guidelines is for use by agencies and practitioners in humanitarian settings. However, these guidelines can also be a useful resource for governments and agencies working in more stable or development situations. Likewise, these guidelines can be helpful additional guidance in refugee situations, but practices would need to take into account broader refugee case management including the specific Best Interest Procedure.

While we have tried to make these guidelines as user-friendly and simple as possible, we have assumed that agencies and staff engaging in case management work have some training and experience in providing care and support to children with child protection concerns.

Training materials on case management have been developed by the CPWG to accompany these guidelines. In addition, there are a number of other training packages and useful resources, which are included in the Resources Section at the end of the guidelines.

Please note that these guidelines are about CASE MANAGEMENT, not child protection programming generally. Inevitably some mention is made of aspects of child protection programming, as case management can be a component of broader programming.

For more information on child protection and child protection programmes generally, in both humanitarian and development contexts, please see the Resources Section.

As every country and community context is different, these guidelines will need to be adapted to the particular environment in which you are working.

⁷. Minimum Standards for Child Protection in Humanitarian Action, Child Protection Working Group, 2012

FORMAT OF THE GUIDELINES

There are three main sections to these guidelines:

SECTION 1 – PRINCIPLES & PRACTICES

This section explores what case management is, in general terms, and the principles that should inform and underpin case management practice.

SECTION 2 – IMPLEMENTING CASE MANAGEMENT SERVICES

This section considers the main dynamics and factors that should be taken into account when either introducing case management services, or seeking to strengthen them. It is primarily aimed at policy makers and programme managers – including child protection advisors and coordinators.

SECTION 3 - CASE MANAGEMENT STEPS

This section examines in greater detail the different steps that form part of the case management process, and the key elements to be considered. It is aimed primarily at frontline caseworkers and their supervisors – that is to say those who actually have the day-to-day contact with children and families. It will also be of use to managers and advisors who have responsibility for either establishing or implementing case management responses and supervising caseworkers.

Throughout the text other key resources that are available have been signposted. In addition, the Resource Section at the end of the guidelines contains a comprehensive list of references and other useful materials.



PRINCIPLES & PRACTICES



SECTION 1

PRINCIPLES & PRACTICES

WHAT IS CASE MANAGEMENT?

CASE MANAGEMENT is a way of organising and carrying out work to address an individual child's (and their family's) needs in an appropriate, systematic and timely manner, through direct support and/or referrals, and in accordance with a project or programme's objectives.

Case management can be provided in emergency and development settings to address a range of issues, including child protection concerns. Case management services can be provided as part of programmes that address the needs of children with particular vulnerabilities or risks (such as separation or commercial sexual exploitation) or may be provided as part of programmes or services that address a broader range of child welfare and social protection concerns. Having case management procedures in place ensures quality, consistency, and coordination of services.

CASE MANAGEMENT IS NOT:

- ↻ A type of programme or intervention – it is a service for identifying children's needs and coordinating services to meet those needs.
- ↻ Appropriate to be used in all circumstances (explored further in Section 2)
- ↻ A quick and easy fix solution – it needs well trained staff, supported by appropriate supervision and is often a medium to long-term work in progress

KEY POINTS ABOUT CASE MANAGEMENT:

1. Should focus on the needs of an *individual child* and their family, ensuring that concerns are addressed systematically in consideration of the *best interests of the child* and building upon the child and family's natural resilience.
2. Should be provided in accordance with the established case management *process*, with each case through a series of steps (as shown below) involving *children's meaningful participation* and family empowerment throughout.

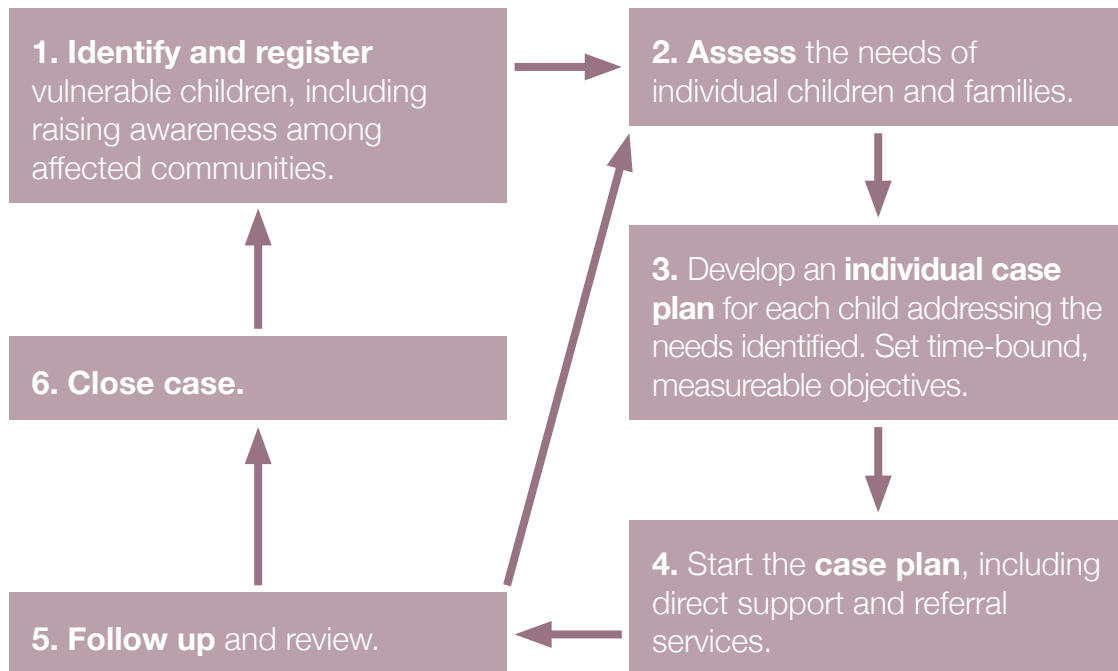
3. Involve the **coordination** of services and supports within an interlinked or referral system
4. Require systems for ensuring the **accountability** of case management agencies (within a formal or statutory system where this exists)
5. Are provided by one key worker (referred to as a **caseworker** or case manager) who is responsible for ensuring that decisions are taken in best interests of the child, the case is managed in accordance with the established process, and who takes responsibility for coordinating the actions of all actors.

CASE MANAGEMENT WHERE FEW SERVICES ARE AVAILABLE

It is sometimes thought that case management cannot be provided where there are limited services for referrals. However, case management services can still be effective when only one agency is working with the child and their family. With appropriate training and supervision, case management staff can address many protection issues themselves and work collaboratively with the community and non-protection services to address potential gaps.

CORE STEPS IN THE CASE MANAGEMENT PROCESS

There are a number of core steps in the case management process (which are described in more detail in Section 3) as shown in the diagram⁸ below:



8. Diagram adapted from the CP MS, Standard 15. Note that in the CPMS case management contains 5 steps as 'Assessment' and 'Case planning' are combined into a single step. In these guidelines, these two aspects of case management are presented as separate steps.

1. IDENTIFICATION & REGISTRATION – A child who is in need of case management services can be identified through a variety of pathways. Staff members in child protection and other sector programmes might identify a child in the course of their regular activities, or an agency or community member might refer the child to receive case management services. In some cases, the child or their family might present themselves directly. Every programme involving case management services should outline specific vulnerability criteria to help guide this identification process and raise awareness on these within a community.

Registration occurs when the child meets the vulnerability or risk criteria and both the child and their family give informed consent/assent to accept services. Registration includes the initial collection of data on the child (intake).

2. ASSESSMENT – The systematic evaluation of the situation of the child. This should consider the vulnerabilities, risks and harm factors, and also the protective influences and strengths and resilience of a child and their family. In emergencies, this may be a relatively quick and straightforward process concentrating on basic needs (for example food and shelter). Where there is an immediate risk to the child (for example the child is living with the perpetrator of abuse or violence), immediate intervention will be prioritized before a comprehensive assessment and case plan is developed.

In a second phase, a subsequent in-depth (comprehensive) assessment is conducted to gain a holistic understanding of the child's situation. The holistic needs of a child are always considered even if an agency is not able to address every concern directly. In such a case, the case would be referred to another agency/service provider able to address specific concern. (See later sections on referrals).

3. CASE PLANNING – A case plan lists the needs identified in the assessment and sets a strategy for addressing them through direct service provision, referrals and/or community-based programmes. In complex cases, a multi-disciplinary, inter-agency case conference may be called to develop a case plan. Specific, measurable, time-bound case objectives are set at this time and should ideally be reached prior to case closure. Case plans are fluid documents that can be revised at any time if a child's situation or needs change.

4. IMPLEMENTING THE CASE PLAN – The actions taken in order to realise the plan including direct support and services and referral to other agencies/service providers, as appropriate. A caseworker or manager is responsible for coordinating all of these services, documenting progress, and ensuring case objectives are being met.

5. FOLLOW UP AND REVIEW –

- **Follow up** involves checking that a child and his/her family are receiving appropriate services and support.
- **Follow-up** also involves monitoring the child's situation and identifying any changes in a child or family's circumstances. Follow-up takes place throughout the case management process.
- **Review** is a reflection on how the implementation of the plan is progressing, whether the objectives outlined in the case plan are being met, whether the plan remains relevant, and how to make adjustments to the plan if necessary.

6. CASE CLOSURE – The point at which work with the child ends. This can be for a variety of reasons – for example because the situation is resolved, (i.e. the case plan has been completed and the child no longer requires support). In some cases an organisation would close a case and transfer the child to another organisation – for example if the child moves to a different location or, in emergency situations, if the organisation is no longer working in the area. The case will also be closed where the child becomes 18 years old (unless there are good reasons to remain involved, such as additional vulnerabilities) or if the child dies.

Managers and caseworkers should keep in mind that case management **is not** a linear process. The six steps shown in the diagram above (Core steps in the case management process p 12) are inter-linked and may at some time trigger a return to an earlier stage or process. Managers and caseworkers should constantly be analysing the situation of children and their family and use the case management steps as flexible tools to organise their work.

■ GUIDING PRINCIPLES FOR CASE MANAGEMENT

Agencies and staff engaged in child protection case management should comply with a core set of principles to guide their behaviour and interaction with children and their families. This also provides a foundation of care and responsibility for decisions and actions taken. These core principles are similar to those which underpin all good practice with children. They also reflect the Protection Principles in the SPHERE Handbook⁹ and the key principles and approaches developed in the CPMS¹⁰.

DO NO HARM

This means ensuring that actions and interventions designed to support the child (and their family) do not expose them to further harm. At each step of the case management process, care must be taken to ensure that no harm comes to children or their families as a result of caseworker conduct, decisions made, or actions taken on behalf of the child or family. Caution should also be taken to ensure that no harm comes to children or families as a result of collecting, storing or sharing their information. For example, care should be taken to avoid creating conflict between individuals, families or communities, and collecting unnecessary information that, if in the wrong hands, could put the child or family at risk of violence. Unless care is taken, this may expose a child and his/her family to further harm such as revenge acts or violence.

PRIORITISE THE BEST INTERESTS OF THE CHILD

The “best interests of the child” encompass a child’s physical and emotional safety (their well-being) as well as their right to positive development. In line with Article 3 of the United Nations Convention on the Rights of the Child (UNCRC), 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*. Caseworkers and their supervisors must constantly evaluate the risks and resources of the child and his environment as well as positive and negative consequences of actions and discuss these with the child and their caregivers when taking decisions. The least harmful course of action is the preferred one.

9. Sphere Minimum Standards

10. Minimum Standards for Child Protection in Humanitarian Action, Child Protection Working Group, 2012

11. Action on the Rights of the Child, <http://www.arc-online.org/using/index.html>

All actions should ensure that the child's rights to safety and on-going development are never compromised.¹¹

The Best Interests Principle must guide all decisions made during the case management process. Often in child protection 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.

NON-DISCRIMINATION

Adhering to the non-discrimination principle means ensuring that children are not discriminated against (treated poorly or denied services) because of their individual characteristics or a group they belong to (e.g. gender, age, socio-economic background, race, religion, ethnicity, disability, sexual orientation or gender identity).

Children in need of protective services should receive assistance from agencies and caseworkers that are trained and skilled to form respectful, non-discriminatory relationships with them, treating them with compassion, empathy and care. Case management staff must actively work to be non-judgemental and avoid negative/ judgemental language in their work. Whether engaged in awareness raising, prevention or response activities agencies and caseworkers should challenge discrimination, including policies and practices that reinforce discrimination.

ADHERE TO ETHICAL STANDARDS

For agencies and staff working with children, professional ethical standards and practices should be developed and applied; these may be professional codes of conduct and child protection policies. National laws and policies may exist in addition to international norms and standards to protect children that are relevant and have to be respected. Adhering to ethical standards includes following the guidelines presented in this document. These guidelines are fundamental to the delivery of professional and quality care and protection for children.

SEEK INFORMED CONSENT AND/OR INFORMED ASSENT

Informed consent is the voluntary agreement of an individual who has the capacity to give consent, and who exercises free and informed choice. In all circumstances, consent should be sought from children and their families or caregivers prior to providing services. To ensure *informed consent*, caseworkers must ensure that children and their families fully understand: the services and options available (i.e. the case management process), potential risks and benefits to receiving services, information that will be collected and how it will be used, and confidentiality and its limits. Caseworkers are responsible for communicating in a child-friendly manner and should encourage the child and their family to ask questions that will help them to make a decision regarding their own situation. (See annex 14, the sample of guidance note for informed consent).

Informed assent is the expressed willingness to participate in services¹². It requires the same child-friendly communication of information outlined above. However, for younger children who are by nature or law too young to give informed consent, but old enough to understand and agree to participate in services, the child's "informed assent" is sought. Even for very young children (those under 5 years old) efforts should be made to explain in language appropriate to their age, what information is being sought, what it will be used for, and how it will be shared.

12. Page 16, Caring for Child Survivors Guidelines, IRC, UNICEF, 2012

In some situations, informed consent may not be possible or may be refused, and yet intervention may still be necessary to protect the child. For example, if a 12-year-old girl is being sexually abused by her father, she may feel loyalty to him and her family and not want to take any action. That does not mean that agencies can ignore what is happening. Where consent is not given, and where the agencies involved have a legal mandate to take actions to protect a child, the reasons for this should be explained and the participation of children and non-offending family members continually encouraged.

RESPECT CONFIDENTIALITY

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 and sharing it only with those individuals who require the information in order to protect the child. Any sensitive and identifying information collected on children should only be shared on a need-to-know basis with as few individuals as possible.

Respecting confidentiality requires service providers to protect information gathered about clients and to ensure it is accessible only with a client’s explicit permission. For agencies and caseworkers involved in case management, it means collecting, keeping, sharing and storing information on individual cases in a safe way and according to agreed upon data protection policies. Workers should not reveal children’s names or any identifying information to anyone not directly involved in the care of the child. This means taking special care in securing case files and documents and avoiding informal conversations with colleagues who may be naturally curious and interested in the work.

Importantly, confidentiality is limited when caseworkers identify safety concerns and need to reach out to other service providers for assistance (e.g. health care workers), or where they are required by law to report crimes. These limits must be explained to children and parents during the informed consent or assent processes. Supervisors and caseworkers should work together closely to take decisions in such cases where confidentiality needs to be broken.

ENSURE ACCOUNTABILITY

Accountability refers to being held responsible for one’s actions and for the results of those actions. Agencies and staff involved in case management are accountable to the child, the family, and the community.

Agencies and individuals providing case management must comply with the national legal and policy framework¹³. They will also have to comply with professional codes of conduct where these exist. In the absence of a legal framework, the guiding principles and the good practice standards outlined in the CPMS provide a foundation for practice.

Agencies introducing or supporting case management services must take responsibility for the initial training, on-going capacity building and regular supervision of staff to ensure appropriate quality of care. This must also provide children and their families with routine opportunities to give feedback on the support and services they have received.

13. There are times when the national legal and policy framework may go against the best interests of the child. In this case, the best interests of the child should prevail and caseworkers should discuss with their supervisors about how best to deal with the situation.

CASE MANAGEMENT SERVICES SHOULD BE:

CHILD FRIENDLY

– entails providing services in ways that are appropriate and accessible for children. For example, by providing information in formats / language that can be understood by children of different ages.

CHILD CENTRED

– entails organizing and delivering services, and making decisions in a way that centers on children's needs and best interests. For example, you should consider holding reviews and meetings at times that are convenient for children and their families, rather than those which fit in with the working hours of staff.

EMPOWER CHILDREN AND FAMILIES TO BUILD UPON THEIR STRENGTHS

All children, and their families, possess resources and skills to help themselves and contribute positively towards finding solutions to their own problems. Caseworkers and supervisors must work to engage children and families to play an active role in the case management process.

Throughout the case management process (including during assessment, case planning, and reviews) case workers should focus on empowering children and their families to recognise, prevent and respond to child protection concerns themselves. In practice, this means that, in addition to identifying problems and providing services, caseworkers must consider the child and family's strengths and resources and how to build their capacity to care for themselves.

UNDERSTANDING RESILIENCE IN CHILDREN

Resilience is a concept that is often talked about in the child protection field and yet it is sometimes misunderstood.

Resilience does not mean that a child is not affected by a situation of crisis; rather it is influenced by the qualities and environmental factors that enable a child to recover and develop positively despite adversity and traumatic experiences.

No one thing makes a child resilient, but there are a number of internal and external factors that can contribute to increased resilience including: a good relationship with a least one caregiver, positive parenting, educational opportunities and social relationships. Importantly, a positive interaction with a caseworker or other service provider can be a factor that increases a child's resilience.

Children who are more resilient tend to have higher self-esteem and self-worth, and have a sense of being able to have some control over their lives / ability to make a difference (locus of control). Caseworkers can support and strengthen these qualities in children by facilitating children's participation, focusing on children and family's strengths and resources, and acting with respect, care and empathy.

For more information see www.resilienceproject.org

While caseworkers are providing an important service, it is ultimately the child and their family's lives that are affected; they must always be active participants in the decisions made for their care. Furthermore, helping children to participate in decision-making is an important part of the recovery process that builds their sense of control over their lives and helps them to develop natural resilience.¹⁴

BASE ALL ACTIONS ON SOUND KNOWLEDGE OF CHILD DEVELOPMENT, CHILD RIGHTS AND CHILD PROTECTION

Assessments and interventions must be made on the basis of knowledge about child development, child rights and child protection (such as understanding vulnerabilities and risk factors, and family dynamics). *Child development* knowledge helps caseworkers to determine how to involve and communicate with children depending on the age and evolving capacities. As standards for the treatment of children vary across cultures and regions, *child rights* knowledge is essential to ensure international norms and standards are respected and incorporated into case decisions. Finally, staff working with children who are affected by humanitarian crises, sexually exploited or unaccompanied or separated should also receive specialized training in handling such sensitive cases. Without such knowledge, case plans may not adequately address children's needs and uphold their rights, and could even be harmful to the child.

FACILITATE MEANINGFUL PARTICIPATION OF CHILDREN

Children have a right to express opinions about their experiences and to participate in decisions that affect their lives. Agencies and caseworkers are responsible for communicating with children their right to participate – including the right not to answer questions that make them uncomfortable – and supporting them to claim this right throughout the case management process. Children's participation helps to prevent a caseworker from coming to a decision that is in their best interests but against their wishes (e.g. removing them from an abusive home), and caseworkers should explain such decisions with care and empathy to the child involved.

Involving children, and their families, in planning and decision-making regarding their own care is critical to ensure services provided are appropriate and effective; furthermore it contributes to children's natural resilience and their ability to be agents for their own protection.

It is important to remember that a child's ability to make decisions is related to their age, maturity, and evolving capacities. Even very young children are able to participate in decisions, although this may take more time and skills from the caseworker to be able to support the child to voice their views. Children have the right to receive information in an appropriate format so that the child understands what is happening throughout the case management process.

In contexts where children's status is weak (e.g. due to gender, ethnicity, or disability) or where it is not culturally or socially acceptable for them to participate, children may be less at ease or feel less confident in participating and in making decisions. Caseworkers have a role to play in encouraging children to voice their concerns and in reassuring them about their ability to take decisions. Particularly in contexts where it may be not safe for children to speak out publicly, caseworkers have a responsibility to create a safe and confidential space for children to participate in their own case. Upholding confidentiality and considering safety in the development of case plans are essential to ensure children are not placed at risk.

14. Resilience is the ability to survive and even thrive under abnormal or difficult decisions. For more information see www.resilienceproject.org

PROVIDE CULTURALLY APPROPRIATE PROCESSES AND SERVICES

Caseworkers and agencies should recognise and respect diversity in the communities where they work and be aware of individual, family, group and community differences. This is important to be able to make an informed and holistic assessment of a child's situation.

Cultural sensitivity also improves caseworkers' capacity to work effectively with children, families and communities and to identify solutions that leverage local methods of care and protection and are in line with the children and families' values and beliefs. Without consideration of the cultural context, the quality of case management services can be hindered, leading to the development of case plans that do not fit the realities of people's lives and beliefs and that may not be acceptable and therefore difficult to implement.

When what is in the best interest of the child conflicts with cultural values or practices, managers and caseworkers must continue to prioritise the child's best interests and take decisions that do not place them in additional risk (do no harm). It may be difficult to identify solutions that are seen as acceptable to the family or community, but managers and caseworkers must make every effort to work with children and families to identify culturally acceptable solutions that at the same time uphold the rights of children. With difficult issues like female genital mutilation, non-education of girls or child labourers, caseworkers should develop harm reduction strategies and seek to address the underlying causes of social conditions. For example, families who send girls to school might be given priority access to cash transfer programmes or livelihood projects.

In some contexts, confronting these protection issues and cultural practices can lead to conflict and may create additional risks for children, families and communities as well as for caseworkers. Decisions made around these issues must include a careful assessment of risk and always respect the principles of do no harm and the best interests of the child.

COORDINATE AND COLLABORATE

Child protection programmes are more effective when agencies work together, and involve communities, families and children in their efforts. Case management can provide a process for improving coordination and collaboration among all actors with a mandate to protect children including community leaders, government departments, service providers, CBOs, local NGOs and international agencies.

Agreed protocols on information sharing and referrals contribute to quality case management and ensure confidentiality and the best interests of the child are upheld. *International organisations, in particular, have a responsibility to coordinate their activities and efforts with national governments and non-government agencies to ensure that existing systems are strengthened and not duplicated.*

MAINTAIN PROFESSIONAL BOUNDARIES & ADDRESSING CONFLICTS OF INTEREST

Caseworkers and agencies should act with integrity by not abusing the power or the trust of the child or their family. Caseworkers must not ask for or accept favours, payments or gifts in exchange for services or support.

Personal and professional limitations and boundaries must be recognised and respected. Steps should be taken to address conflicts of interest where these arise. An example of a conflict of interest might be where the caseworker and child are in some way related or from the same social network, or where the caseworker working with the child is also the caseworker for the perpetrator of the abuse.



Caseworkers and agencies should take action to resolve these issues in a way that is positive for the child so that children are neither negatively affected nor given an unfair benefit as a result.

OBSERVE MANDATORY REPORTING LAWS AND POLICIES

Many countries have mandatory reporting requirements, which oblige certain actors (such as child protection agencies and staff, teachers, nurses and doctors) to report cases of child abuse to relevant government authorities. However, these requirements can be challenging for caseworkers when the information is of such a sensitive nature that it cannot be shared with other actors without placing the child at risk of further harm.

This is of particular concern when data protection protocols are not in place or are not strictly followed. In humanitarian settings, where there is concern about the safety and security of those involved, it is good practice to deal with reporting decisions on a case by case basis, informed by the local standards and practices applicable in the country of operation, and always guided by the best interests of the child.

Agencies working with children should have their own internal child protection / safeguarding policies that should be complied with at all times (See Reference Section for further information). Often these set higher standards regarding the responsibilities of staff and expected behaviour than that sanctioned in law.



ESTABLISHING AND STRENGTHENING CASE MANAGEMENT SERVICES



SECTION 2

ESTABLISHING AND STRENGTHENING CASE MANAGEMENT SERVICES

This section is especially written for Child Protection Managers, Coordinators / Advisors and other programme staff who may have input or involvement in establishing or strengthening case management services within a child protection programme.

These guidelines will help you to plan and design the appropriate case management procedures as part of your child protection programme and within the context of the wider child protection system¹⁵. This includes taking into account the existing processes within the country, both formal and informal, and analysing the need and relevance for a case management response.

Section 3 gives more detailed information regarding the specific steps of case management, and you may find it useful to also refer to that section when designing your case management procedures.

■ CONTEXTS FOR ESTABLISHING / STRENGTHENING CASE MANAGEMENT SERVICES

There are five main contexts in which you might be considering introducing case management services:

1. In emergencies, with the intention that once the emergency is over, the case management services are phased out. This would be appropriate where the case management services being established do not serve the general population and are not appropriate for transition once the emergency is over, where no existing system is in place, or where the system is not functional to respond to the rapid needs of the caseload.
2. In emergencies, with the idea that the processes established will form the basis of the national child welfare system as the country moves into recovery or development phases.
3. In emergencies or development contexts, where existing case management services require significant additional capacity building to meet the needs of affected populations.
4. In development contexts, where no system is in place. In this context, the government must be involved from the start in negotiations about how to introduce a case management services, what this will look like and how it will interact with existing government structures.
5. In middle income or developed countries where the child protection system and case management services are in place, with trained staff and resources but not reaching a particular group of the population such as asylum seekers.

¹⁵. These can be broadly defined as the people, processes, laws, institutions and behaviours that normally protect children, in line with the definition in the CPMS (principle 5).



In each of these circumstances there are a number of competing interests and influences that need to be carefully considered during initial planning stages. Managers and advisors should always seek to build on existing formal and informal mechanisms, recognizing that governments have the ultimate responsibility for the children in their country. This should not, however, prevent non-governmental agencies from responding to children's needs when government structures are either unable or unwilling to provide services. In such cases, capacity-building efforts and policy change efforts can be paired with small-scale case management services to meet urgent needs.

INTRODUCING CASE MANAGEMENT IN EMERGENCIES

Emergencies are humanitarian crises that can frequently overwhelm the resources and capacity of affected communities and societies to cope, and therefore require urgent action. Emergencies tend to fall into one of two categories:

- sudden or rapid onset emergencies
- chronic emergencies that develop gradually but may continue for years

Different types of emergencies present different challenges and opportunities for integrating case management into existing child protection systems. These can be both formal and informal systems.¹⁶ While you should take into account the informal systems and include them as part of the interventions that might be offered through the case management process, the management of cases should be carried out within the formal system to maintain accountability and consistency. Particularly when communities are impacted by an emergency, where case management is needed and they may lack the capacity or resources to implement a case management system.

During an emergency, child protection systems and case management processes are often overwhelmed by the nature and scale of child protection needs as pre-existing protection concerns increase and new protection concerns arise. Additionally existing systems and structures are typically weakened by the impact of the emergency.

In emergencies, while new procedures and mechanisms for protecting children, including case management, may need to be established, child protection agencies should support efforts to protect children by building the capacity of child protection staff generally and supplementing the existing resources and procedures with technical support.

When case management services are introduced in emergencies, they should be approached with the longer-term strengthening of the child protection system in mind. Balancing immediate and longer term needs can help lay the foundation for further development of the child protection system when the country moves into a recovery or development phase. However, this can be difficult to do for a number of reasons: a) in emergencies a rapid response is needed, and there may be little time either to consider extensively the context or to get consensus with all stakeholders; b) in reality the government may look to international organisations to take the lead; and c) while it may be ideal to engage upon a lengthy exercise in consultation and analysis, children need to be protected and efforts to respond to their needs should not be delayed.

16. Explain the difference between formal/informal systems

In emergencies, agencies can balance these competing priorities by considering the following:

1. **Concentrate on building core child protection skills and capacities** (for example child development and assessment) that can be easily transferred as mechanisms and processes are created or strengthened throughout the child protection system.
2. **Concentrate on the basics and keep it simple.** Case management procedures can be highly complex and detailed, but only keep the main elements (as discussed in Section 1 of this guide) so that efforts are not wasted, or can be maintained by governments with limited resources as international organisations reduce their assistance.
3. **Ensure timeliness of the response.** When many organisations are working together to coordinate their response and support the government, this often results in lengthy negotiation processes to agree on forms, protocols and SOPs for how all the parties will work together. Limiting the time it takes to come to these agreements is essential to ensure that children are supported as soon as possible following the onset of the emergency. Basic agreements should be fast-tracked to facilitate an urgent response; they can later be revised and expanded upon.

INTRODUCING/STRENGTHENING CASE MANAGEMENT IN A DEVELOPMENT CONTEXT

Introducing or strengthening case management in a development context is a different process and takes much more time. It should involve extensive consultation and collaboration with governments and other relevant agencies and organisations. A sense of ownership of processes should be encouraged from the start, while providing appropriate technical support, to ensure the sustainability of case management services within a wider child protection system.

As mentioned in Section 1, case management is not suitable for all child protection programmes. Case management takes a considerable amount of work and effort, and as a result time and resources can be wasted without a clear understanding of what is feasible given the existing context and capacities. In addition the administrative requirements of the case management procedures do not outweigh the actual time spent supporting and working with families.

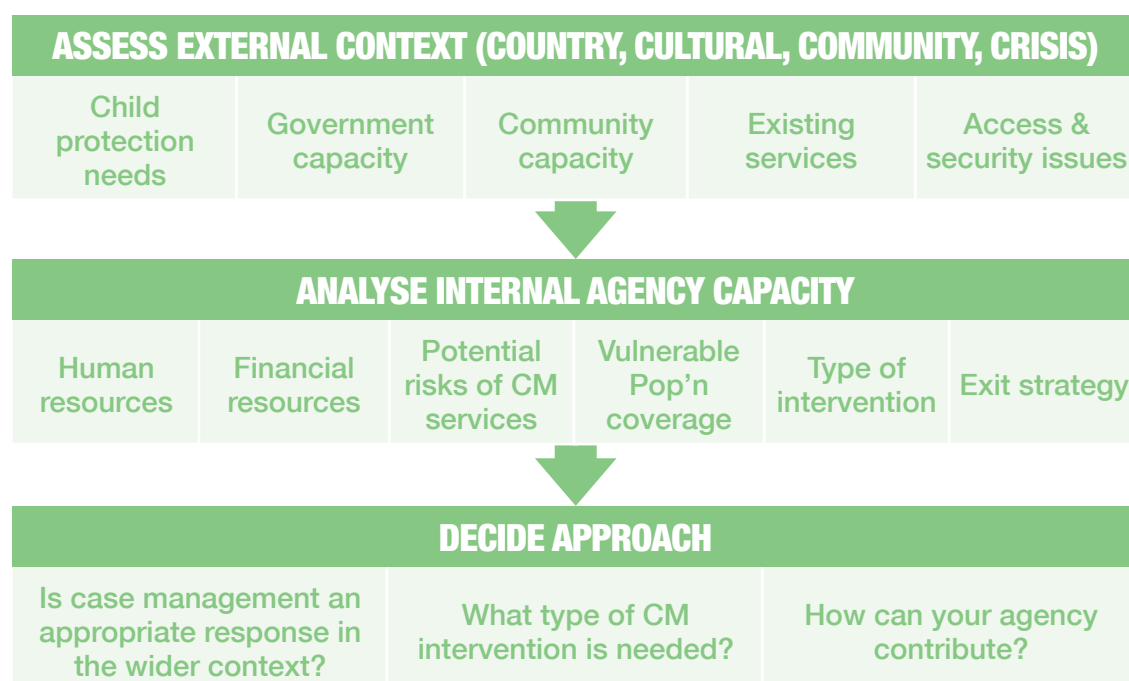


Case management services are needed where:	Case management services are not recommended where:
<ul style="list-style-type: none">➤ Children are harmed or at risk of being harmed and need individual attention / specific planned interventions to meet their needs and ensuring they are protected.➤ There is an expectation that support needed is likely to be on-going and comprehensive – with short, medium and long term actions➤ Where the focus of the intervention is on individuals, rather than on communities generally	<ul style="list-style-type: none">➤ Services are concentrated on basic needs – for example food distribution only – although you may want to refer specific children for additional support, if children are recognised as needing complex support or in situations of abuse➤ Contact with the child / family is likely to be limited to one or two sessions; problems are transferred to other agencies and resolved quickly; and there is no expectation that the child will need on-going support / intervention➤ There are already other processes for handling cases that are functioning and comprehensive➤ Where existing interventions and programmes focus on groups, rather than individual children and families➤ Where security threats cannot be mitigated and compromise the safety of the information, the caseworkers or the children.

■ ANALYSING EXTERNAL AND INTERNAL CAPACITIES AND CONSTRAINTS

If your organisation is thinking about developing or engaging in case management services within your child protection programme, you will need to analyse the operating environment outside of your agency, along with the capacity and constraints within your agency, to inform your planning and decision making.

The diagram below captures the key elements in this process of external context analysis and internal agency analysis.



Assessing the wider context in which you are working will require you to gather information on a range of issues including:

- the nature and scale of child protection needs to be addressed
- the existing capacity of social welfare and child protection systems including resources (both human and financial), legislation and policy frameworks
- available services and critical gaps in service provision
- existing referral mechanisms for identification of children at risk and the extent to which marginalised children are able to access services
- coordination mechanisms between different government and non-government agencies, and linkages with communities – including responsibility for which functions and where/ how could your agency fits within this
- access and security

This information can be gained from country reports, humanitarian situation reports, multi-sectorial needs assessments, and general or rapid child protection needs assessments that may have already been conducted. Consultation should also take place with key stakeholders, including children, families and communities. Some form of capacity mapping should be carried out to identify existing services and gaps in service provision.



Analyse

- How your agency can best contribute to a case management response in line with the guiding principles and the CPMS, and taking into consideration external and internal capacities and constraints.

Decide

- Whether case management is an appropriate response in the wider context of existing governmental, non-governmental and community-based child protection mechanisms, in which your agency is working;

THE ROLE OF GOVERNMENT

Both humanitarian and development actors are mandated to support governments in fulfilling their obligations, **not to replace them**. Agencies should respect the government's lead responsibility in child protection and explore ways to strengthen existing systems, even where the services available may not be ideal. In large-scale emergencies, this may involve ensuring government representation in coordination functions even if a major part of the implementation of case management services has been outsourced to external actors.

Where possible and appropriate, governments should be supported to deliver direct case management services for vulnerable children and to link with additional services. Indeed, in contexts where there are qualified social workers within national agencies, external actors should not be carrying out case management but should be supporting existing social workers and the existing case management processes, or filling gaps where capacity and resources are low.

When seeking to engage in case management, and adapt these guidelines to your context, it is critical to assess and to work with the pre-existing child protection systems and procedures. This includes:

- linking with relevant government structures and key agencies / organisations
- using or building upon existing case management services
- complying with the international and national legal framework
- identifying existing positive community practices for child care and protection
- coordinating with other actors, and clarifying roles and responsibilities
- understanding the culture of the communities
- ensuring appropriate accountability mechanisms are in place

The role of the government becomes most critical in decisions with a statutory / legal component, such as removal of children from care-giving arrangements where they are at risk of harm, placement of children in alternative care arrangements, or in complex family reunification situations. In some settings the government provides such services directly, while in other contexts the government may mandate a partner agency to engage in service provision. In situations where government capacity and presence is extremely limited, you will still need to seek local authorisation and participation in decisions regarding the change of care situations for children.

Even in the apparent absence of government services during some emergencies, agencies engaging in case management decisions are still accountable and liable under domestic legal frameworks. As such it is imperative that you check under which authority you are taking decisions concerning children and your agency's mandate. You should seek advice from your agency on the adequacy of legal cover provided through agency to government agreements.

In situations where the government itself is a party to conflict, or has lost control over territories, there may be tensions between building national capacity and protecting children. In such situations, the timely protection of children must be the primary consideration in accordance with humanitarian principles of impartial assistance based on need, and ensuring safety and dignity for the most vulnerable. In such contexts, it is essential to be aware of the risks associated with sharing information on individual cases and the importance of confidentiality and informed consent to ensure protection of the child.

THE ROLE OF COMMUNITY AND TRADITIONAL LEADERSHIP

A community may not always be a homogenous group and understanding of what constitutes a community can vary from place to place. In these guidelines, "community" is defined geographically, as in the CPMS, as *"a group of people living in or near a particular location, such as a village or an urban neighbourhood"*.

Communities can play a significant role in preventing and responding to child protection risks¹⁷. However, setting up a community based child protection mechanism, such as a child protection committee, does not guarantee that all children are protected. Such mechanisms need regular capacity building and monitoring to ensure that they continue to protect children.

There is a distinction between:

Community-Based Interventions – introduced by external agencies, such as child protection committees

Community Practices – are accepted ways of doing things to respond to given situations, and which are likely to be more sustainable. Whenever possible, child protection programming should seek to capitalise on positive community practice.

Community-based child protection programming aims to reduce vulnerabilities and risks to children by building a protective environment at family and community levels. Effective prevention programming requires active awareness-raising and engagement with communities on child protection concerns, to reinforce protective practices and to encourage social and behavioural change to address negative or harmful practices. Similarly, effective government or non-governmental child protection response programmes depend significantly on levels of cooperation and linkage with community-based mechanisms (Child Protection Committees, parent's groups, traditional justice systems, etc.).

Communities play an important role in identifying children who are at risk of harm and are in need of services in support. It is necessary to understand the existing services, support, and child protection actors within the community, to include these in referral mechanisms, and to engage them in the identification process. In some contexts, it may also be important to work with community members, such as traditional leaders, to develop or carry out the child's care plan.

17. Child Protection Minimum Standards in Humanitarian Action - Standard 16: Community-based Mechanisms, p143



Community-based child protection mechanisms can play a role in a number of important activities including:

- ↻ Identifying vulnerable children and children at-risk of harm or being harmed
- ↻ Supporting parents and families
- ↻ Identifying and supporting foster families
- ↻ Providing emergency items and services like clothes, food or school fees for the most vulnerable
- ↻ Enforcing codes of conduct in schools and health centres
- ↻ Community awareness raising on CP issues
- ↻ Integration of minorities and children with disabilities
- ↻ Including and engaging children and families in community events (e.g. religious or traditional ceremonies to empower children and enhance their sense of belonging)
- ↻ Holding political and religious leaders accountable
- ↻ Supporting social reintegration of individual cases
- ↻ Mediation

Community-based child protection mechanisms may or may not have a formal mandate and accountability as part of the recognised formal child protection system. This will affect their role and mandate in relation to any case management process. In some instances, criteria or thresholds may be set regarding the kinds of cases that may be handled at the community level and those that should be referred to the formal child protection system.

Community members who are formal or informal focal points for children (e.g. teachers and health workers) should be trained to identify and refer child protection cases to the child protection case management services. In some statutory systems, these workers may be mandated to report child abuse. In other contexts, there may be little or no linkage between formal case management services (where they exist), and mechanisms that exist within communities. In such contexts, working with communities to strengthen these linkages is a critical part of efforts to develop systems and ultimately to protect children.

Even if not formally part of the child case management process, there are ways in which communities can engage in the case management process. Community-based child protection mechanisms may have focal people for referring child protection cases to formal services. Child-focused service providers working within communities can also be responsible for identification and referral of children into case management services.

In other settings you may find that customary law prevailing over formal legal processes. Working with traditional leaders is important to identify customary legal practices that are protective of children and broadly consistent with international law. Support for such practices combined with the involvement of professional child protection actors can help to improve protection for at-risk children.

THE ROLE OF CHILDREN & FAMILIES

Children and their families also play an important role in the case management process – both in terms of their involvement in the development and review own case plan (discussed in Section 3) and in terms of helping to design, review and improve case management procedures.

Children and families who have participated in case management services are best able to give feedback on their experiences of the process. This valuable information can be used as part of the monitoring function, and in reviewing and refining procedures as they develop.

EXISTING SERVICES

Different services are required to respond to different types of child protection needs. The availability and quality of the required range of services will vary depending on the context.

The service and capacity mapping should identify both available resources and critical gaps in service provision. Strategies for addressing gaps should be defined, including how their absence will be communicated to the child and their family/community.

Knowing what services are available for referral will enable all children to have access to assistance and appropriate support. For example, if you are providing case management only for unaccompanied and especially vulnerable separated children¹⁸ it may be appropriate to refer all other separated children directly to other organisations for family tracing and other services. You should not ignore child protection issues simply because appropriate services are not available. You and your agency should advocate with national and international actors for this gap in services to be filled.

■ ANALYSE INTERNAL AGENCY CAPACITY

In addition to assessing the appropriateness and need for a case management response in the given context, you will also need to critically consider your agency's capacity to adopt and undertake case management services within your child protection programme.

It is important to be realistic in terms of your reach and capacity, and the ability to build your response to the required level. In some cases, and wherever possible, agencies should work together to develop case management processes to agree on standard practices. This will also facilitate the sharing of resources and expertise.

On-going review of both your child protection programme, and any case management services introduced, is required in order to ensure that they are appropriate, relevant and continue to meet needs, as the context changes and develops. The strategy for this review needs to be identified and implemented.

In thinking about your own agency, you will need to consider the following points in detail. Some of these elements relate to your child protection programme generally, as this will in turn affect whether a case management services can, and should be adopted:

18. ICRC will typically document only children who require tracing i.e. those who have lost contact with family members (UASC Handbook draft 2, 2012).



- ↻ Population coverage
- ↻ Services available
- ↻ Types of intervention
- ↻ Risks to security and safety
- ↻ Number of staff and skills of staff, including access to external support
- ↻ Budget
- ↻ Transition and/ or exit strategy

HUMAN RESOURCES

The number of staff you have, and their levels of competence to both carry out and supervise case management is a critical determinant of the scale and nature of your response. You have to assess your agency's ability to address your staffing resources and the need for capacity building. Case management staff need both initial training on core skills (e.g. child protection, case management process, communication with children, etc.) as well as on-going supervision and mentoring to ensure these skills are put into practice. (See appendices for core competencies for case management staff.)

If, in the planning phase, you do not have the resources or minimum capacity to provide case management services, then you should not proceed or you should refine your criteria for registering children, in line with your capacity. This does not mean that you cannot continue to implement a child protection programme or engage in activities to support effective case management within the wider child protection system. Examples of such activities include: providing technical support to government and non-government child protection actors engaged in case management; direct provision or capacity building of associated child protection services (e.g. health workers, police, legal support); advocacy to address critical service gaps or issues within the child protection legal, policy and institutional framework; and support to government to establish formal, university-level, social work training programmes.

FINANCIAL RESOURCES

Information gathered on the needs and required response will give you an indication of the costs and financial resources required (an example budget is included in the resources section). Depending on the case management procedures you design, funds may be needed for:

- ↻ *Office set-up*: (office space, furniture and infrastructure such as computers, internet, items for proper information management such as a case file cabinet and stationery)
- ↻ *Appropriate space*: in order to ensure confidentiality and privacy during meetings with children and families
- ↻ *Salaries*: the number and type of caseworkers needed will depend on their planned tasks. Additional administrative support may also be required.
- ↻ *Supervision and training*: capacity to deliver on-going training, support and supervision of caseworkers and managers is essential for an effective case management procedure.
- ↻ *Transportation*: for example for home visits (such as a vehicle, money for fuel and maintenance.)
- ↻ *Communication*: such as a duty phone for caseworkers to contact families.
- ↻ *Emergency money*: (sometimes referred to as an Emergency Case Fund) to enable immediate response when needed, such as emergency medical care¹⁹, and assure your agency is meeting its duty of care to children and families.

19. Guidance for Emergency Case Funds: They must be authorised easily and administered locally to serve their purpose; they must be in place in grants; they should have some boundaries (e.g. linked to the case plan or for key emergency issues); they must be clearly explained to the client for transparency and to minimise expectations of further support at regular intervals. They should not be regular or on going, or seen as being the purpose of casework as this can distort the relationship.

POTENTIAL RISKS

Agencies have a mandate to “do no harm”. Therefore, before starting any child protection programme, or adopting a case management services, you will need to carefully consider the risks and benefits to the child, family, community, and the agency itself. The staff, children and families involved should understand the potential risks associated with case management.

You need to bear in mind that:

- *Collecting information on individual children’s cases can place those children at risk.* Depending on the sensitivity of the information and its relevance to the management of the case, you may decide that some information should be collected while other information should not. You will need to create a plan for how to mitigate the risks that children and their families could face if confidentiality is broken or the information collected is seized or stolen. Your agency’s data protection and sharing protocols should include plans for how to handle data in case of evacuation, including moving or destroying the most sensitive documents.
- *Potential unintended consequences of providing individual case management can arise,* particularly where referral services do not exist. Registration, documentation and drawing attention to particular individuals or groups can increase protection risks. Case management services can also create a ‘pull factor’ leading, for example, to family separation, including across borders, where there is a perception that children may have access to better care and services if they fall into the UASC category of vulnerability serviced by your programme. These must be considered and mitigated in accordance with the do no harm principle.
- *Risk to caseworkers.* Managers of agencies implementing case management, including governments, should include safety and security training for staff and ensure that safety and security policies are in place. These might include ensuring staff do not go on home visits alone, establishing check in policies, and other procedures to reduce risk to caseworkers’ safety. Cultural sensitivity and awareness of any existing tensions should also be emphasizing in caseworker training as it contributes to acceptance within communities and the overall safety and neutrality of the staff and agency.

VULNERABLE POPULATION

You will need to determine the size of the affected population that is at risk and who is available to respond to their needs. Initial rapid needs assessments in emergencies, child protection system mapping exercises, as well as agency registration data may give an indication of the vulnerabilities and risks for children in a given location.



DISTINGUISHING BETWEEN VULNERABILITY AND RISK

Remember, vulnerability and risk are not the same thing, although they are closely linked.

Vulnerability refers to physical, social, economic and environmental factors that increase a child's susceptibility to protection concerns and other hazards and difficulties.

Vulnerability factors might include: displacement, lacking parental care (unaccompanied children), disabilities, or association with armed forces and armed groups.

Risk refers to the likelihood that harm or a protection violation will happen. Risk considers the probability of internal and external threats occurring in combination with existing vulnerabilities and is mitigated by protective factors.

Assessment of risk needs careful consideration of the whole situation of the child – not just identification with a list of indicators from a checklist. This is explored further in Section 3.

TYPES OF INTERVENTION

In determining your agency's role and the focus of your child protection programme and case management services within the wider child protection system, the interventions you seek to provide should not only match the needs of the population being served, but also be coordinated with and not duplicate other services being provided. For example, a key aspect of establishing a child protection programme where there are high rates of gender-based violence will involve working with the health sector, and any case management procedures will need to take that into account.

EXIT STRATEGY

On the basis of your analysis of both the external context in which you are working, and your internal agency capacity to engage in case management, you can decide: whether case management is appropriate; whether it is possible at the current time given services and support available; who is best placed to do it; what support they need; and the roles and responsibilities of your programming response.

Many programmes involve case management, or elements of the approach. As has been said earlier, before you start implementing your own case management procedures, you should first explore ways to strengthen existing procedures and the child protection system, wherever possible.

You also need to decide and plan for how you are going to withdraw/transition and what is the legacy you are going to leave. Something too ambitious, resource intensive or which does not 'fit' within the current context is unlikely to be sustainable. Governments, other agencies, communities and families may have unrealistic ideas of your agency's period of involvement in the country.

Given the limited resources normally available for child protection, resources must be used effectively. This also guards against these resources being diverted into supporting procedures which are not suitable or viable in the longer term.

As with child protection programming generally, when planning your case management response you need also to start planning your exit strategy, and talk with key stakeholders and partners about what this means.

At an individual level, careful consideration will need to be made as to how to transition / transfer cases which are still involved in your case management services as you withdraw. This is important to ensure that children continue to receive the care and protection they need, and have a right to, and so that they are not unintentionally harmed through the process of closing your response.

COMPLEMENTARY ACTIVITIES AS ALTERNATIVES TO ESTABLISHING CASE MANAGEMENT

As mentioned earlier, although case management is often recommended as part of national child protection systems, and should be considered as a possible approach in humanitarian crises, it may not always be feasible or appropriate for non-statutory child protection agencies to develop and implement case management procedures and processes for a range of reasons.

Where this is the case, or where your own agency lacks the resources to implement a case management response, you can still contribute to case management by:

- Providing specialist capacity building, support and supervision
- Supporting the development of procedures and protocols
- Facilitating interagency cooperation and collaboration through network and coordination meetings.

In deciding your best course of action, you should be guided by the priority of strengthening existing systems (rather than building new, parallel systems) and the principle of do no harm.

- Case management can also be used as an approach within prevention or early intervention programmes. This may mean that the children in your caseload are identified on the basis of vulnerability, rather than actual risk level or harm.
- In contexts where access to affected communities is limited by security or logistics, case management may not be a feasible intervention. In these contexts, it may be appropriate to map available services and develop referral pathways, raise awareness in communities of available services and how to access them, train community focal points on child protection issues and appropriate responses, and provide financial and / or logistic support to individual children and families to facilitate their access to services. Whilst such interventions lack the oversight of individual cases and accountability necessary to be considered case management, they may create the building blocks upon which a case management service may be developed at a later point when security and logistic constraints have been addressed.

The following contextual considerations may also inform your decision making:

- Case management applies to *individual* children. In situations where an entire population's basic needs are not met, individual cases cannot be opened for each child. Broader social welfare programmes will be required to respond to the scale of need.



- In contexts where strong case management processes and capacities already exist, it may be valuable to provide training to existing child protection caseworkers to enable them to further develop their skills and better respond to child protection cases in emergency and non-emergency situations.
- In contexts with a weak or non-existent statutory framework for child protection, and where child protection capacity is limited, it may be most appropriate to start with community-based child protection programming and capacity building of authorities, who can later lead the development of a child protection system and case management processes tailored to the context.
- The nature and scale of child protection issues in humanitarian contexts may be overwhelming, such that it may not be feasible to implement a case management process that addresses all child protection needs at once. In these contexts, it may be appropriate to develop a case management procedure that focuses on specific issues initially (e.g. urgent, emergency-related issues such as family separation or release from armed forces or armed groups). This can then be used as a building block to develop a more comprehensive case management service over time that addresses the full range of child protection issues.
- There may be situations in which it is appropriate to establish a case management system that is separate from the formal (i.e. government) case management services because there are risks to children in having their information shared with State authorities. This is particularly true in conflict-affected humanitarian contexts, when the state is party to the conflict and case management is required to address child protection issues (e.g. killing and maiming, abduction, recruitment, detention or sexual violence) that are related to the conflict. A parallel system is also applicable when the formal or judicial system takes a punitive approach to child protection issues such as sexual violence. In contexts such as these, additional consideration should be given to defining an exit strategy, including handover and storage of information on children, before initiating a case management service.

ESSENTIAL ELEMENTS OF DESIGNING & IMPLEMENTING CASE MANAGEMENT SERVICES

Once you have decided that case management is appropriate, you then need to design and implement it within your programme.

Four main issues need to be considered:

- Vulnerability criteria for registering children
- Human resources and staff capacities and competencies
- Information management systems
- Safe working practices

Each case management procedure should have a detailed set of 'operational guidelines', which are specifically tailored to the context.

VULNERABILITY, RISK & ELIGIBILITY CRITERIA

Depending on the scale of your programme and the extent to which the case management services are used, you will need to develop vulnerability criteria in order to identify and target children who *might* be in need of protection.

Vulnerability is context-specific – just because a child falls into a particular category (for example has a disability) does not mean that they are necessarily vulnerable – it depends on each individual child's situation. You should develop vulnerability criteria that reflect your programme context and constraints as well as your expertise and capacity (see some example of vulnerability criteria in the resources section). Building on definitions that already exist, you should consult with children, their families, community leaders and those working with children to agree on shared criteria to define who is a vulnerable child in the given context.

If vulnerability criteria are not in place, you will risk:

- Missing/ not reaching children most at risk
- Creating confusion with the community regarding the purpose of case management
- Facing high caseloads and possible staff burn out
- Implementing a programme that is not appropriately tailored to the specific needs of children and / or overwhelming the limits of your response

Vulnerability criteria help to screen cases in situations where there are large numbers of children in need of support and an initial assessment tool to help differentiate and identify cases that may be in urgent need. Before defining the vulnerability criteria, an analysis should be done to look at which children are experiencing or at risk of experiencing harm within your context and should take into account several factors in relation to the child, such as age, sex and disability amongst others²⁰.

20. CPMS, Defining Vulnerability, Standard 15, page 139.



Vulnerability criteria should be:

- *Detailed*: clearly list the categories of vulnerability that need intervention. This may include other sector-related vulnerabilities and risks (e.g. health, shelter) as well as child protection vulnerabilities and risks.
- *Transparent*: develop the criteria with the involvement of affected children, their families and communities
- *Realistic*: base the criteria on your analysis of the child protection needs in the context, which of the needs you aim to address and how, the risks that may be involved in responding, and your available resources to respond.

You should share your vulnerability criteria with other child protection actors to ensure they are aware of your intended coverage of the vulnerable population and how you plan to manage the caseload. Given the changing environment and protection dynamics in humanitarian settings it is worthwhile to conduct a periodic review of criteria.

RISK LEVELS

As mentioned before, vulnerability factors do not necessarily indicate a specific level of risk, and case management staff must be able to evaluate a child's entire situation to assess actual risk levels. Child protection case management staff should understand risk and its cumulative nature in order to prioritise between cases in need of more intense and less intense interventions.

TYPICAL RISK LEVELS:

HIGH RISK – Child needs urgent medical attention, is likely to be seriously harmed or injured, or subjected to immediate and on-going sexual abuse, or be permanently disabled, trafficked or die if left in his/her present circumstances without protective intervention.

MEDIUM RISK – A child is likely to suffer some degree of harm without an effective protective intervention plan. Intervention is warranted. However, there is no evidence that the child is at risk of imminent serious injury or death.

LOW RISK – The home is safe for children. However, there are concerns about the potential for a child to be at risk if services are not provided to prevent the need for protective intervention.

Risk also needs to be considered in relation to harm to the child in the immediate, short, medium and long term. For example, some forms of abuse, such as emotional abuse, have a lower impact in the short and medium term, but over the long term can be extremely damaging for children.

Within your case management procedures, it is essential to identify how risk is measured and assessed and expectations in terms of time periods for action. Developing these guidelines with your staff will help to create a sense of ownership (and thus they are much more likely to be followed) and shared understanding across the team, increasing consistency of approach. This is discussed further in Section 3.

HUMAN RESOURCES

Good case management practice is underpinned by well supervised, experienced, trained, and where possible, certified staff who have the time and resources to carry out their work.

Number of Staff/ number of child-to-staff ratio

Caseworkers must have a reasonable caseload, reflecting their skills and capacities. The CPMS state that the number of cases allocated to each caseworker should not be more than 25. However, this will need to be considered according to the specific programme that is being implemented as in some cases this will be more than can be managed. Factors to consider include:

- *Referrals*: are your caseworkers responsible for providing in-house services or are they only making and following-up on referrals made?
- *Responsibilities*: what is the scope of the caseworker's responsibilities (e.g. are caseworkers also responsible for other tasks such as community liaison)?
- *Complexity*: what is the level of complexity of the assessments or interventions? Note that different cadres of staff may be required to handle different levels of complexity and have different types of caseloads
- *Administrative responsibilities*: do your caseworkers have significant administrative responsibilities? Is there data entry and administrative support available and access to technology?

Supervisors or managers should review the caseload of individual workers to ensure it is manageable at least once every 2 weeks. In the onset of an emergency, there may be extreme pressure to scale-up and reach a larger caseload. If you have an existing policy on caseload quotas, you should review this to determine how increasing the caseload will impact the programme and staff, and the financial and human resources required to support an expanded programme.

Skills and Competencies of Staff

When providing case management services – whether you are working with a government or non-government agency – you should ensure that your staff have appropriate skills and competencies to carry out case management interventions in a safe and professional manner.

Assessment of skills and competencies of the staff should take place as part of the recruitment processes. A skill and competency framework is annexed to these guidelines, which can be used to guide recruitment and capacity building for supervisors and caseworkers.

Qualifications of Caseworkers

Caseworkers and supervisors should have, at minimum, prior experience working with children as well as appropriate social work certifications (degree/diploma/certificate) where possible. In countries where social work programmes and certifications are not available, advocacy with the government to introduce such programmes of study is vital as part of the programmatic response. It should be noted that in some contexts, experience may be more valuable than certifications, so having a case worker with 15 years of experience working with children and families but with no degree may be better than having a recent graduate with a certification in social work but little to no experience of working with children.



In some countries there is a system that regulates who can practice certain types of formal social work functions, sometimes referred to as ‘statutory services’²¹ (for example representing cases to court). This may involve systems of training and qualification. It is recommended that where such systems are in place, they are made compulsory through regulation or licensing. Where there are standards or regulations regarding qualifications, you should seek to ensure that your staff are qualified to at least this level.

Recruitment of qualified staff by international aid agencies engaging in case management work should not result in the loss of qualified staff from government agencies in the long term. The number of child protection staff who leave a government job in order to join an international organisation should decrease over time if appropriate support is being provided to build the national child protection system.

Capacity Building

Before starting capacity building activities, you must conduct an assessment of the staff’s attitudes, skills and knowledge to appropriately target capacity building initiatives. In many cases, staff will need initial training on foundation knowledge areas, such as child development and risk assessments.

Capacity building is more than just initial training; staff also need to have the opportunity for on going / refresher training and mentoring. Practice and mentoring are recognised as an important way to learn and apply teaching and to develop skills and competencies. This can be carried out in a number of ways – through supervision, from technical support within the team, from outside or from peers. However, it must be carried out by someone who themselves has substantive child protection and case management experience, otherwise key elements of knowledge may be missing.

Depending on the roles that caseworkers perform they may need additional training on other services they can provide directly as part of case management, such as psychosocial support and family mediation. They may also need training on specific issues, such as how to respond to cases of sexual violence. These more thematic issues can be explored through a programme of on-going training helping develop knowledge and skills.

In training staff, you should differentiate between the different roles and responsibilities and tailor training accordingly. Additional training may be needed for managers and supervisors, on responsibilities such as supervision and how to represent their organisation in coordination meetings.

Supervision

All caseworkers should be provided with supervision – both informal and more structured. Supervision supports technical competence and practice, encourages reflection, promotes wellbeing and enables effective and supportive monitoring of casework. When planning to engage in case management, you should consider the ratio of the ratio of caseworkers to supervisors, to determine the number of supervisors needed for appropriate supervision (e.g. 1 supervisor for 5-6 caseworkers).

21. Statutory functions are tasks undertaken within the legal framework, such as decision making around care placements or removals, actual processing of care placements or adoption through courts, advising courts on decisions regarding where a child lives.

You also need to consider whether the knowledge and skills required for supervising case management exist. For example, often managers are expected to supervise staff, but they may lack technical knowledge on child protection and case management as they have been recruited for their programme management skills. In addition, staff may be reluctant to engage in supervision with managers if they think it affects their annual report. In these cases, someone other than the line manager can facilitate the supervision of individual caseworkers and practice. This should be a suitably qualified and experienced colleague (not necessarily someone more senior), or someone from another agency / consultancy. The function and purpose of supervision within case management are:²²

1. Supervision of individual cases and professional practice (or ‘Clinical Supervision’): this involves the supervisor routinely meeting with the caseworker and helping them to find solutions to challenging cases; it enables reflection and learning from practice to identify professional development needs and build caseworkers’ capacity on an on-going basis. It also supports monitoring of how difficult cases are managed and changes in the situation for the child.

2. Support for personal wellbeing: supervision is an opportunity to seek and receive emotional support to prevent and respond to negative impacts on caseworkers resulting from exposure to challenging cases (e.g. burn out). Strategies for self-care should also be promoted through supervision ensuring caseworkers have appropriate coping skills and techniques.

3. Support for wider processes: this may include operational challenges that the supervisor can raise with management for resolution. It can support mediation of these issues (where the supervisor acts as a bridge between the individual staff member and the organisation).

Caseworkers can also be supervised in a group setting (that is with a supervisor facilitating discussions among caseworkers). This can be an effective way of developing skills, sharing experiences and bringing cohesion to a team.

Another important function in supporting the work of staff is management. This is less to do with the quality and content of casework but more associated with the performance of the caseworker in relation to their job. This is different to case work supervision, where the focus is on what is happening for / to the child rather than the activities of the worker (although there is a link). Management supervision is about knowing what a team or individual is doing to ensure processes are well administered and programmes are successful. This may include performance management of individual staff including efficiency and accountability.

Inclusion of such functions as part of case management supervision is difficult to do in a balanced way and needs a lot of skill to ensure that it is properly facilitated. For this reason, it is strongly discouraged; if the two processes are combined it is critical to ensure that performance management should not dominate case management supervision.

Staff at all levels should be supervised, including managers and supervisors themselves. If processes are designed in such a way that staff are encouraged and supported to reflect on their practice, a culture of openness and transparency is more likely to be fostered, resulting in better outcomes for children.

22. Adapted from Carpenter J., Webb, C. and Coomber, C. (2012) Effective supervision in social work and social care, Social Care Institute for Excellence Research Briefing 43.



The confidentiality principle should also apply in supervision. If caseworkers have a physical space to discuss and seek advice in regard to difficult cases in a confidential manner, this will reduce the risk of breaching confidentiality commitments to the child.

INFORMATION MANAGEMENT

In setting up a case management service, a safe and confidential system for collecting, storing and sharing information is imperative. You need to ensure that all staff understand and comply with information management protocols including processes for appropriate documentation, record keeping, database access and use, and sharing of information with others.

Documentation and record keeping

Documentation is the process of collecting and storing information specific to individual children and their families, including information that the child and family provide directly as well as any information collected indirectly.

IMPORTANCE OF FILES & RECORDS

While government departments or international agencies may be collecting and storing documentation, they are doing so on behalf of children and families. This information belongs to the children and families concerned and they are entitled to see their case files.

This will need to be done in a sensitive manner as it may be upsetting for the child. It may also be necessary to screen files to ensure that confidentiality of others mentioned in the files is not broken.

Caseworkers, agencies and government departments are the custodians of the child's information and have the responsibility to protect it on behalf of the child.

Caseworkers should be encouraged to write case notes and complete other documentation (such as forms) with care and accuracy. Case notes should be based on fact and professional judgment rather than on personal bias. Language that is dismissive, judgmental, or offensive should be avoided. The information collected about the children belongs to the children themselves, and they should have access to review and read the information at any time as part of their meaningful participation.

Proper documentation facilitates effective and accountable case management. Good record keeping is a professional and ethical responsibility, and in some countries a legal obligation.

The development and use of case management forms supports the documentation process. Where possible forms should be standardised within and across agencies and sectors as this helps ensure uniformity in documentation across the entire caseload and facilitates more effective information sharing. Standardized data collection processes enables program staff to aggregate (or disaggregate) data to track trends. This information can then be used to support planning and decision-making.

Various examples of standard case management forms and tools, which can be adapted to your context, are provided as annexes to these guidelines. Be aware that there is a great deal of temptation to develop complex forms, which gather enormous amounts of data but in reality do little to protect children. A complicated set of forms with extensive checklists is no substitute for simpler forms that are well understood by workers with the capacity to be able to make professional judgements.

If the government has their own case management forms, other agencies should use the same forms or ensure that their forms are appropriately linked with those of the government. If standard forms are to be developed, or existing forms are to be harmonised, this should be done through a process of consultation as quickly as possible and should not delay the registration process for children at risk.

Record Keeping

Records should be kept in a way that is confidential and in line with ethics, law and confidentiality principles (see Section 1).

At minimum, there should be:

- A separate case file for each child that is well-organised with key information presented in a standard, structured way;
- A code (that does not identify the child) allocated to each case file and marked on the front of the case file (names should not be recorded on the front of case files). This supports confidentiality and tracking of individual cases. A list which links the case file codes with the children's names should be stored in a different location from where the files are stored. This code can also be used when saving word documents and sending emails related to the case.
- An updated record placed on file for each activity that occurs. This can either be a direct contact, such as when a family is visited or indirect, for example if the teacher calls into the office to discuss how things are going in school.
- A separate section of each file marked 'strictly confidential' to store information that is particularly sensitive and cannot be shared with certain actors is included

In addition files should be kept in a secure location, with restricted access, such as a locked filing cabinet and there should be a separate filing system for highly sensitive files and instructions to destroy files in the event of evacuation. Case file audits can be used to check for breaches of data protection and information sharing protocols.

Databases²³

As part of your assessment of the case management context, you should identify the case management databases that are already operating within your own agency, and other agencies in the country and explore options for using the same database or linking with them.

23. There are many case registration and case management databases belonging to different organisations. Some of these databases support registration while others support full case management (eg IA CP IMS and Tdh'sPillango). These should not be confused with incident reporting systems such as the GBV IMS, or the MRM database.



It is important to distinguish between registration databases (for record-keeping only) and case management databases (for documenting and managing case flow). Where databases are used for case management they should:

- Be adapted to the case management process
- Enable timeframes for individual cases to be set and tracked
- Be harmonised through the use of standard forms to enable common statistics to be generated and facilitate inter-agency referrals.
- Support caseload management through caseload review and allocation of cases to individual caseworkers.
- Be supported by appropriately skilled data entry and data management staff. The number of data entry staff often depends on the capacity of the staff to use computers and technology.²⁴ Staff responsible for data entry and management should be fully integrated into the child protection team and included in child protection training and capacity-building activities to ensure they understand child protection concerns and response processes, and especially data protection/confidentiality issues.

The Inter-Agency Child Protection Information Management System (IA CP IMS)

The IA CP IMS was developed in 2005, through the collaboration of IRC, Save the Children UK, and UNICEF. Since then it has undergone several phases of enhancement and is used by a wide number of agencies as well as governments to support their case management service. It can be used across a variety of child protection programmes in emergency, early recovery or development settings.

The IA CP IMS has four main components:

1. A set of standard paper forms that can be adapted or used as they are;
2. An electronic database in which children's information is recorded;
3. Information sharing protocols;
4. Data protection protocols.

Training can be provided on customising and using the IA CP IMS and a manual is available to all agencies: www.childprotectionims.org

While a case management database is recommended where there is likely to be a high volume of cases to cope with the amount of information, databases alone do not result in effective case management. What is needed is a system for recording information, tracking cases and tasks. This can also be done through good paper records and a simple spread sheet. You need to make sure that you remember that the database is a tool to support the case management, not case management itself.

Data Protection Protocols

Data protection relates to the protection of all personal data collected, either through individual interviews or other means, including the receipt of secondary data from known or unknown sources.

²⁴ A rough guide is that data entry personnel with strong IT skills should be responsible for approximately 100 cases. Where caseworkers have good IT skills, it may not be necessary to have dedicated data entry staff – in this case, the ratio would be 1:25 children.

Agencies involved in case management must develop data protection protocols based on the principles of confidentiality and “need to know”, with the ultimate aim of safeguarding the best interests of the child. Data protection protocols serve as a guide for what information to collect; how the information will be used; and how the information will be stored. Legal provisions within the country and case-specific protection concerns may determine how long information is stored. In cases that involve adoption or alternative care arrangements, information may need to be stored long after case closure.

Information Sharing Protocols

As multiple agencies or government departments are working together to address the needs of children, through the provision of multiple services and referral pathways, it is essential to also develop agreed information sharing protocols, which define what information about the children should be shared, when and with whom. How this information will be shared, verbally, electronically or through a paper system, also needs to be defined with appropriate procedures to ensure that the confidentiality of the child is protected and respected at all times.

(See the appendix section for examples of data protection and information sharing protocols.)

SAFE WORKING PRACTICES

Child Safeguarding Procedures

Each agency should have its own child protection policy that outlines what steps the organization will take to protect children from harm and respond to protection concerns.

At minimum, your agency should have codes of conduct in place for staff, including expectations about reporting concerns, and data protection protocols. You must ensure that caseworkers sign up to these commitments and understand the implications for their work.

Mandatory Reporting

When setting up case management processes, or indeed in child protection programming more generally, you must ensure that your agency and staff understand national mandatory reporting laws and policies, and how they are practiced or followed. This information will directly impact how the caseworker explains these rules and regulations to the child and family.

In some settings, particularly humanitarian ones, 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 at further risk of harm. In such situations, the best interests of the child must be the primary consideration. You will need to determine to whom staff members should report cases that fall within mandatory requirements and the chain of supervision for reporting. Your agency may choose to make reporting of certain child protection concerns mandatory in line with your child protection policy / code of conduct for staff.



CASE MANAGEMENT STEPS



SECTION 3

CASE MANAGEMENT STEPS

This section examines in greater detail the different steps of the case management process, and key factors to consider at each step of the process. It is aimed primarily at caseworkers and their supervisors – that is to say those who actually have the day-to-day contact with children and families. It will also be of use to managers, advisors and coordinators who are designing case management procedures and responsible for their implementation.

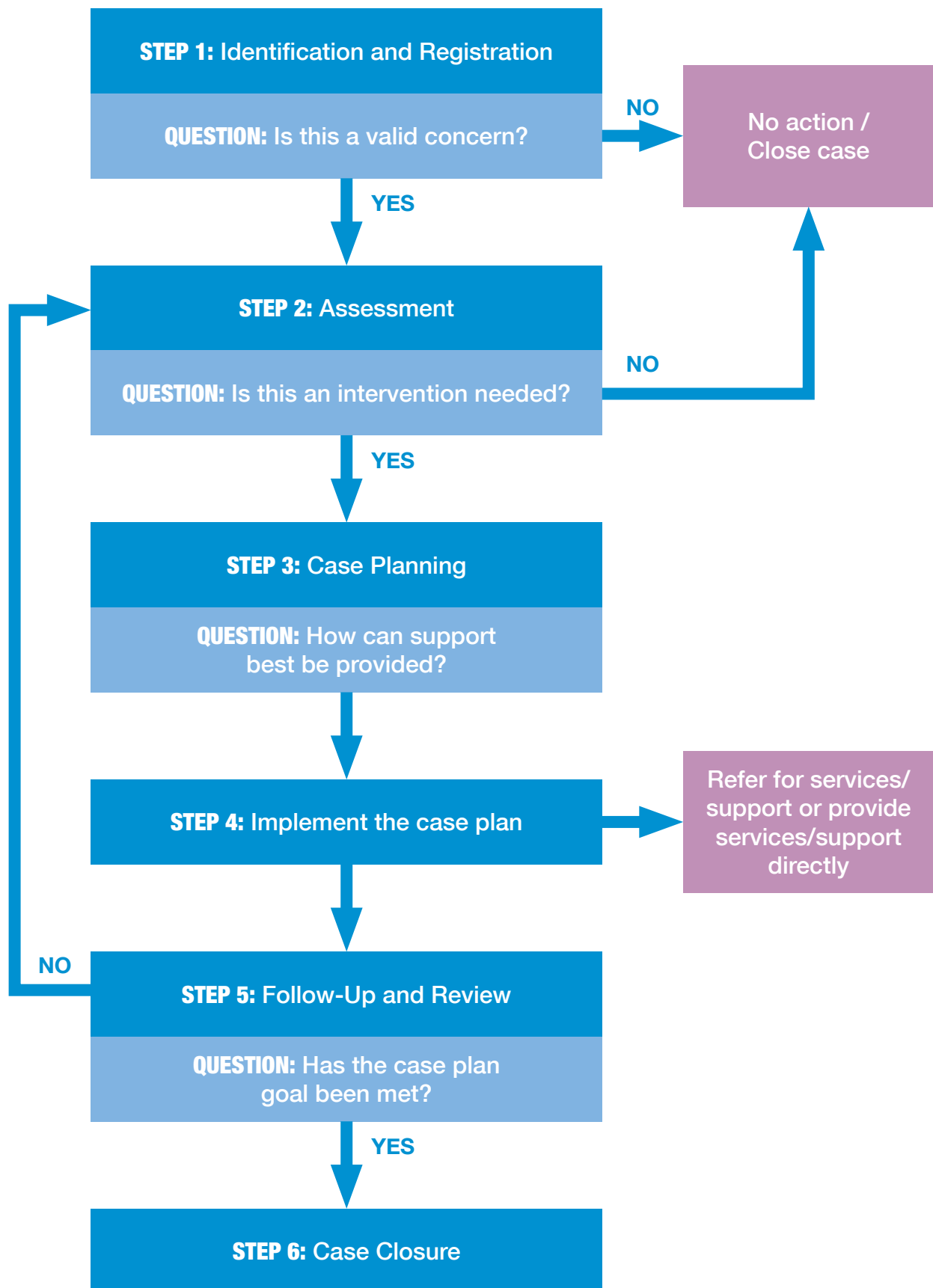
Case management generally follows a cycle of steps to identify and respond to the needs of vulnerable children. While not always the same for every child's situation, the case management process generally moves through the phases described below²⁵

1. Identification/Registration
2. Assessment (initial & comprehensive levels of assessment)
3. Case Planning
4. Implementation of the Case Plan
5. Follow Up and Review
6. Case Closure

The diagram²⁶ on the following page summarises the steps in case management. Remember the steps outlined here are included for general information, to provide guidance and examples. You should consult your own case management protocols for specific guidance on issues such as time frames, risk levels and responsibilities, in line with the context in which you are working.

25. Note that in the CPMS case management contains 5 steps as 'Assessment' and 'Case planning' are combined into a single step. In these guidelines, these two aspects of case management are presented as separate steps.

26. Adapted from Tdh. Case Management Handbook for Child Protection Workers 2013 (draft)



■ STEP 1 - IDENTIFICATION AND REGISTRATION

Children harmed or at risk of being harmed can be identified by a variety of sources including community members, child protection committees, government authorities, asylum-seeker and refugee registration processes, self-referral (by the child or family) and other agencies providing services, or staff within your child protection programmes. To ensure that vulnerable children are appropriately identified, awareness-raising needs to be done among the affected communities so that they are aware of what services your agency provides and how to identify children who are in need of those services.

Once the children have been identified, they should be referred to the child protection agency or focal point in the community. This person will screen or verify that these cases meet the vulnerability criteria agreed for your child protection programme. In some cases, you may receive cases that do not meet your agency's eligibility criteria. It is important that you know of other services (e.g health services) that you can immediately refer the child to or that you are able to provide the child and his/her family with information about other services that they can turn to for support.

Where children who fall outside your organization's eligibility criteria are consistently being referred to your organization, follow up with other organizations and community focal points to clarify the services your agency provides. Also keep programme managers informed so that decisions can be made about whether the criteria needs to be reassessed.



Once a child has been identified and referred to the correct child protection agency, they should be registered with that agency. Key basic information should be obtained during the registration process, using a standard format agreed as part of standard operating procedures. Information collected is likely to include:

- ↳ child's name, age and sex²⁷
- ↳ who the child is living/ staying with (if anyone)
- ↳ where the child is currently staying and contact details
- ↳ date and location where they are registered
- ↳ initial protection concerns/ needs

At this time the child should be assigned an individual case number to avoid confusion between children, facilitate easy retrieval of records and to ensure confidentiality.

27. In some situations, it is accepted that the gender of children may not match their biological sex, such as for transgender or intersex children. If this is the case, it may be more correct to ask the gender of children rather than their sex.

CASE STUDY: Identification

It is critical that all actors are alert to children who may be at risk of abuse, or who are suffering abuse, and make referrals to the Child Protection Units to ensure that children are appropriately protected.

The following case illustrates how a child at risk was identified, and how various actors worked together to ensure that the child was protected and the family given the necessary support to enable the family to remain together. It also illustrates how a child was instrumental in the protection of another child, and highlights how children can play a key role in their own protection.

Case Background:

K was 13 years old, and was living with his mother and three sisters. K's father had been working in a neighbouring country for five years. When returning home, he used to frequently abuse K's mother in front of the children, following his wife's movements and spending all the money earned overseas on alcohol.

K's mother was very attentive to the children's needs but felt that the violence that she suffered had damaged her both physically and mentally. She once tried to escape from her husband with her children, but returned home, as she was not able to survive alone without support. She finally decided to divorce him and moved with her children to seek a new future in another city. Unfortunately K's father did not accept the decision to divorce and continued harassing his wife and children, to the extent that the police were called.

The family was extremely poor and had consequently been expelled from their rented apartment.

Intervention:

K talked about his situation with a classmate, who told their teacher. K's schoolteacher then reported the case to the school psychologist who conducted a preliminary assessment. The School Director was informed and the case was passed to the Regional Coordinator of School Psychologists who then referred it to the CPU in the area.

The Child Protection Worker met with the mother, with the school psychologist, to discuss the problems in the family, and then organised a case conference. The meeting resulted in a concrete case plan for K and his family. This included a work placement for the mother so that she could be independent and support her family and on-going support and monitoring of the children to ensure their safety and help them cope with their experiences.

Terre des Hommes. Case Management Experience from the Field: Case Studies from Albania.

■ STEP 2 - ASSESSMENT

Assessment is a process of gathering and analysing information in order to form a professional judgement about the child's situation. During an assessment, a case worker considers not only the immediate risks that the child faces, but also the child and family's strengths, resources and protective influences.

It is not an exercise just in gathering information, but provides the basis on which subsequent decision will be made. Careful thought should be put into how the assessment is conducted and how the child and their family are involved, as this is the first opportunity for a caseworker to develop a positive relationship with the child.

Regardless of the type or nature of the assessment, all assessments should include the same basic stages:

Stage One – Planning: deciding how to carry out the assessment, where will information be sought and who will be involved

Stage Two – Gathering Information: what information will be collected and how

Stage Three – Verifying Information: cross checking where there are differences between information, information is incomplete or contradictory. It may be that some children or others give contradictory information themselves, either accidentally or for reasons of their own. As their caseworker, you will need to cross check this information, identify the contradictory information and try to resolve the differences.

Stage Four – Analysis: making sense of information in terms of how it relates to the situation for the child, their needs and risk.

There are two types of assessment that can be conducted:

Initial Assessment

This should take place ideally within the first 24 hours following identification and registration or sooner if the child is in urgent need (e.g. in a life-threatening situation). In practice, initial assessments are often carried out as part of the registration process. If this is not possible, the initial assessment should be completed within no longer than 48 hours, otherwise a child could be left at risk.

Wherever possible, the caseworker who will work with the child should be the one to carry out the initial assessment and use age-appropriate, child friendly interview techniques to include the child in the process. This is the first opportunity for the caseworker to establish a relationship with the child and family that will form a core part of the direct services provided as part of the case management process.

The initial assessment considers:

- Immediate physical protection, health and safety
- Basic needs such as food, shelter, medical care

Depending on how busy the child protection programme and case management workloads are, a priority level should be assigned to each case at initial assessment in order to ensure cases are handled in a timely way. Time limits and prioritisation categories are context-specific and should be developed in consultation with agencies assisting in the response, however an example could be²⁸:

Risk Level	Description	Timeframe
High Risk	Child needs urgent medical attention, is likely to be seriously harmed or injured, or subjected to immediate and on-going sexual abuse, or be permanently disabled, trafficked or die if left in his/her present circumstances without protective intervention.	Intervention should be done ideally before leaving the child. Report immediately to Supervisor
Medium Risk	A child is likely to suffer some degree of harm without an effective protective intervention plan. Intervention is warranted. However, there is no evidence that the child is at risk of imminent serious injury or death.	Intervention should be done within 72 hours
Low Risk	The home is safe for children. However, there are concerns about the potential for a child to be at risk if services are not provided to prevent the need for protective intervention.	Intervention should be done within 1 week

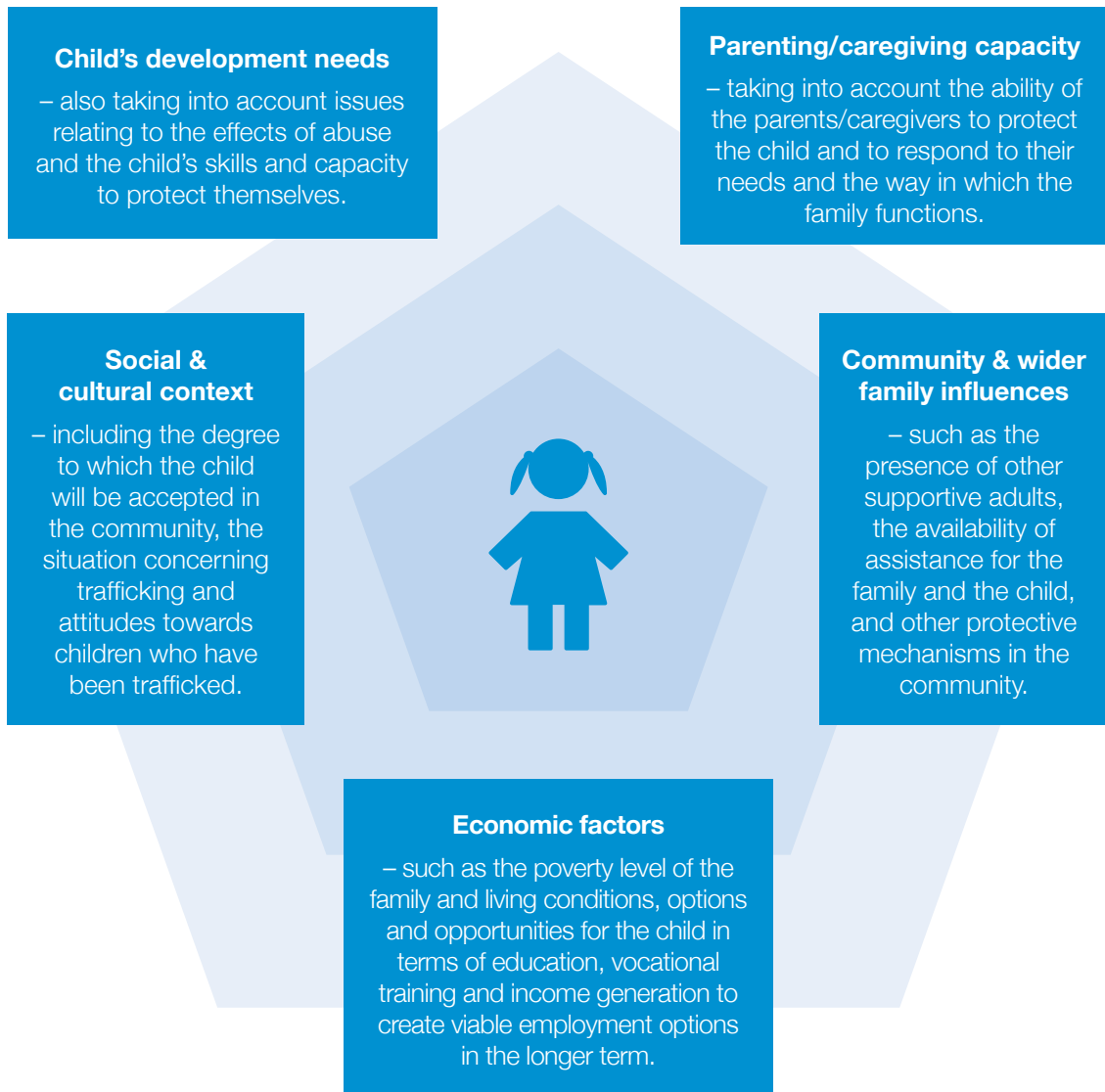
Following initial assessment it is also possible to close a case if it is apparent there are no concerns (e.g. perhaps identified / registered in error) or the case is transferred to an agency better able to help and support.

Regardless of the risk level, caseworkers should conclude the assessment by discussing what next steps to plan with the child and their family. Regular monitoring should begin at this point, with home visits or phone calls to ensure the situation remains stable. Frequency of monitoring will depend on the risk level (e.g. twice a week for high risk, one a week for medium risk, once every two weeks for low risk).

28. Case Management Handbook for Child Protection Workers, Tdh, 2013. (Draft)

Comprehensive Assessment

A comprehensive assessment follows the initial assessment and provides a more in-depth and holistic view of the child's situation. A comprehensive assessment looks beyond just a child's basic, immediate needs. Factors considered during a comprehensive assessment may depend on the scope of services provided by your agency. However, comprehensive assessments typically assess:²⁹



A comprehensive assessment should not only consider risks and harm factors, but also identify positive, protective influences and strengths.

29. Ibid.(Numerous variations of the Assessment Triangle have been reproduced. For the official version, please see www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4003256)

THE ASSESSMENT PROCESS AND INVOLVING CHILDREN

Remember that you will not be able to collect all information at one time. Very young or distressed children may take several sessions to feel comfortable enough to provide information (if ever), or it may take them time to remember information about themselves and their past. As a caseworker, you should make sure that you use different techniques (e.g. drawing, storytelling, etc.) to gather as much information as possible from the child in a manner that helps them feel comfortable. However, you should not attempt to use techniques that you have no experience or training in, and you **MUST** be careful not to stray into attempting to provide therapy.

This includes ensuring that your approach is child-friendly, using simple clear language, age-appropriate concepts and making sure that the assessment takes place in a setting where the child feels safe.

Children should understand why they are being asked questions and for what purpose the information will be used. This includes explaining confidentiality and its limits. Caseworkers must explain that they will not share children's information without their permission. However, they may need to reach out to someone for additional help if they have safety concerns or mandatory reporting duties.

While children should be encouraged to participate and speak out, they should never be placed under pressure to do so, or threatened or punished if they refuse.

The comprehensive assessment is the basis on which all other casework is done.

The wishes and opinions of the child **MUST** be sought and taken into consideration when making decisions. This does not mean you have to do what a child wants – it is the adult's responsibility to protect and promote the best interest of the child – but the child should be helped to understand, even if they do not agree, what you have decided and how you came to that decision.

How long a comprehensive assessment takes will vary according to the context as well as the needs of the individual child. Rushing an assessment may mean that crucial information is ignored, while taking too long may mean that the child is placed at further risk of harm. Priority must be given to addressing the child's most pressing needs, while gathering further information on their situation. When your initial assessment has identified that a child has a basic unmet need / is unsafe then you should ensure that immediate services are provided as needed (as an interim case plan) while the comprehensive assessment is completed.

The CPMS indicate that an assessment should be carried out within one week of the child being registered and that the case plan must be initiated two weeks after the assessment is completed.

An assessment provides a ‘snapshot’ of a child’s situation and wellbeing and as such changes over time, as more information becomes known or the circumstances for the child change. It can be tempting to ‘wait and see’ especially when key information is outstanding, but this can lead to the child ending in limbo (often known as ‘drift’). For this reason, the comprehensive assessment should always be completed within a month maximum and should be done more quickly in emergency contexts. The assessment should be revised and updated throughout the process of review.

Information for the assessment can come from a variety of sources including available reports/information on the child, observations and interviews with the child and their family, discussion with other agencies and those who know the child and home visits. You can gather this information using a variety of tools, including discussions /interviews, checklists, activities, questionnaires and scales.

When undertaking an assessment, it is normally more helpful for you to identify *needs* rather than services required (known as needs-led assessments). For example, you should say a child is *in need of education* rather than saying the child needs to go to school. There are many different ways of providing a child with an education (such as tutors, education clubs and literacy groups) - school is just one way. Especially where resources are scarce, expressing needs can be helpful in encouraging people to be creative about finding solutions, rather than being focused on the lack of services. The other danger in service-led assessments is that you may end up just allocating services that exist rather than meeting needs.

Making Decisions in the Child’s Best Interests – The Situation for Refugees

In refugee operations, a specific best interests procedure has been established for situations where equivalent national procedures are not available or accessible to refugee children. The best interests procedure is the standard for assessment, case planning and general case management for refugee children. This process is detailed in the *UNHCR BID Guidelines* and *UNHCR/IRC Field Handbook*.³⁰ The BID form is for instance a specific and absolute requirement for a number of resettlement countries which accept unaccompanied and separated children. In refugee operations, case management of children is also linked to the broader refugee case management – starting from refugee registration and ending with implementation of durable solutions.

The best interests procedure includes two complementary steps: the first step is conducting a **Best Interests Assessment (BIA)**, a comprehensive assessment and case-plan addressing the child’s individual needs. The second step is the **Best Interests Determination (BID)**, applicable in 5 distinct situations³¹ requiring a formal process with strict procedural safeguards designed to determine the child’s best interests for particularly important decisions affecting the child. BID decisions must be approved by a specialized panel, which should be composed whenever possible by government officials, partner agencies with different backgrounds and expertise in child protection and other related areas, and UNHCR staff. The BID process should support national child protection structures and is designed to be integrated into a comprehensive child protection system.

30. UNHCR Guidelines on Determining the Best Interests of the Child, May 2008 and UNHCR Field Handbook for the Implementation of UNHCR BID Guidelines, November 2011

31. Five specific grounds for conducting a BID; 1) Durable Solutions - voluntary repatriation; local integration or resettlement) – this should be considered for all UASC within a 2 year period; 2) Separation from Parents: The possible separation of a child from her/his parents or other recognized caregiver; 3) Unresolved custody disputes: Where custody of the child in regard to her/his parents or other recognized caregiver remains unresolved; 4) Exceptional Temporary Care Arrangements: Temporary care arrangements for unaccompanied or separated children; 5) Exceptional Family Reunification Cases. See UNHCR, Field Handbook for the Implementation of UNHCR BID Guidelines, November 2011, p9

CASE STUDY: Assessment

This case study shows that gathering full and reliable assessment information can take a long time, and explores the risks children can be exposed to if interventions are not made.

A case was identified of a 13-year-old girl being cared for by a woman who said she was her aunt, but the person referring the case did not believe this. The woman was a sex worker and the person referring the case was concerned for the girl's safety.

It took six months for the caseworker to gather evidence that the girl had been trafficked. The caseworker made many visits to the home, including with the government caseworker. Interviews showed that information the aunt gave about the child's early history was inconsistent and home visits showed that the girl did all housework for the 'aunt'.

However, the girl refused to speak when interviewed in front of her 'aunt' and the 'aunt' refused for her to be interviewed separately. The person who referred the case was scared to report to the police as the woman was protected by a criminal gang. Therefore, there was no evidence on which to remove the child from the aunt's care under the law.

The caseworker passed messages to the girl through neighbours about where she could find safe shelter if able to run away. Eventually the girl did run away to one of the neighbours' homes. The neighbour alerted the caseworker who then relocated her to a place of safety. The girl then disappeared for some months. Following negotiation with the extended family and the government caseworker and police, the girl was brought back to the 'aunt'. She was then removed through court order by the government caseworker and immediately taken to a place of safety in another city. DNA tests were conducted for two families claiming to be her relatives and after some weeks of preparation she was reunited with her family.

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■ STEP 3 - CASE PLANNING

Within two weeks of the assessment being completed, a case plan should be developed. This plan should be based on the assessment and identify what should happen to meet the identified needs, who should do it, and when the actions should take place. It should also include a plan for routine monitoring of the child's situation, with frequency depending on the risk level and the needs of the child. The case plan should consider: immediate, short-term, medium term and long-term actions. Where possible and appropriate, the child should be provided with a simple written copy of the plan that they can understand. This is especially important when some of the action points are their responsibility to take forward.

Addressing child protection risks often requires a family-centered approach that identifies the needs and capacities of the family and works to strengthen the family's capacity to protect and care for the child. It is crucial that you do not raise the expectations of the child/family that they will be able to receive services and support that are not actually available.



The child and family should be fully involved in the development of the case plan. In some cases, a case worker may convene a formal case-planning meeting that involves the other significant people in the child's life as well as other service providers and relevant authorities where possible and appropriate. If you convene a case-planning meeting, you will need to think about how to ensure that the child and family can fully participate in a meaningful way.

When drawing up the plan it is useful to also build into the plan **contingencies** for what to do if the plan fails, or an action cannot be carried out. This might be as simple as reconvening another case planning meeting to develop a new plan.

Appointment of a Keyworker and Consistency of Caseworker

One staff member, or keyworker, should act the main point of contact for the child and family throughout their case. In most situations the caseworker or case manager also acts as the keyworker.

Even though they may not be responsible for undertaking all case management functions and services, the caseworker is responsible for coordinating and following up the actions of all agencies and individuals involved in the case. The caseworker must ensure that progress is being made towards objectives set out in the case plan and that decisions are being taken in the best interest of the child.

Ideally, the same case worker carries out the assessment, case planning, and follow up; however, there may be some circumstances where it is necessary to change case workers. This could be because the child / family has a poor relationship with the worker (sometimes families can be unhappy or angry with the outcome of the assessment, particularly if they feel criticised or judged). Alternatively the assessment could raise a specific reason why the child would benefit from a particular type of worker – for example a female.

Two other concepts are useful to keep in mind when developing case plans:

Twin Track Planning – having two or more alternative courses of action that are pursued simultaneously in order to prevent delay. For example if a child is not attending school you might consider *both* trying to enroll the child in school and to look for a tutor.

Permanency Planning – case plans for a child should address their short, medium and long term needs. Solutions should be sought that are durable and long term. This can be difficult in humanitarian situations where there is a lot of uncertainty, but it always remains in the best interest of the child to aim towards longer term planning.

CASE STUDY: Case planning

This case study shows twin track planning for a 15 months old baby boy experiencing and at risk of further severe neglect and physical abuse. His mother broke his arm after an aggressive outburst due to a mental disorder she was living with. He was delayed in his development, having not yet started to crawl, and malnourished. The house was in poor condition, with human faeces left around the home. The father was under significant stress from looking after his wife and children without paid employment. The two older children had left school to care for the mother and the baby. Neighbours rarely helped as they were afraid of the mother. The mental health worker said the mother's condition and behaviour had consistently and significantly improved over the past year as a result of medication.

In close coordination with the government caseworker, it was decided to closely monitor the care provided to the children while supporting the family to provide care. The community would be mobilised to be on stand-by to provide interim care if needed. Other actions:

- Caseworker to provide the family with non-food items and their own latrine (within 1 week)
- Advocate to shelter agency for provision of a better shelter (within 1 week)
- Advocate to agencies for the father to find employment (within 1 week)
- Enroll the father in counselling and parenting classes – direct service (within 1 week)
- Refer baby to early childhood development programme – direct service (within 1 Case Study – Case Planning month)
- Plan with family and community to manage the household chores so children can return to school (within 1 month)
- Closely follow-up mother's condition with the health agency (fortnightly)

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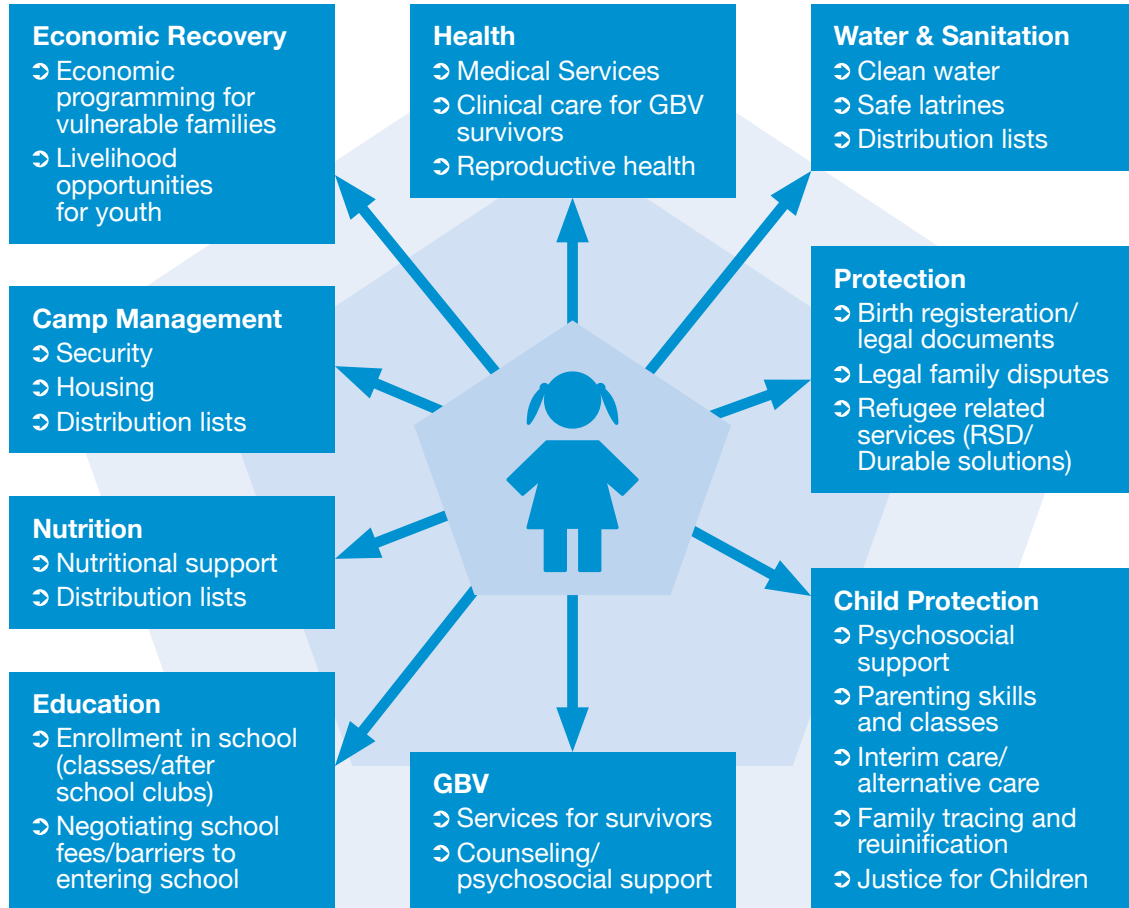
STEP 4 - IMPLEMENTING THE CASE PLAN

Once the case plan is developed, it is then possible to move onto the next step of implementing the plan. Based on the plan, you should work with the child, the family, the community and any service providers to ensure the child receives the appropriate services.

You may provide direct services according to need (for example advocacy or parenting advice). An essential direct service provided is the psychosocial support done by the caseworker themselves during regular monitoring and other meetings with the child and the family. Using child friendly communication, providing advice on daily challenges, and being a resource for the family are key ways that caseworkers can develop a positive relationship with the family. These routine interactions are a unique form of psychosocial support, which can contribute to the entire family's wellbeing when done correctly.

You can also formally refer the case to an appropriate service provider through a process called 'referral' whereby you link the child with necessary services. This is normally only done with the permission of the child and family and when the agency is unable to meet the child and family's needs without outside assistance. Where possible, caseworkers should accompany the child / family to the service provider, at least for the first time, to help with introductions and ensure the referral is understood by the agency receiving it.

The visual below shows examples of the various types of support and direct services that may be required to respond to the child protection needs identified in the assessment stage.



Referrals often work best when the caseworker is familiar with the services offered and the staff providing those services. As such, you should continually educate yourself about relevant services and service providers within the referral network. It is important to note that while the referred service (or agency) is responsible for providing a specific service, the caseworker maintains the overall responsibility to follow up on the case plan with the child and service provider to ensure that the needs of the child are fully met.

The establishment of a referral mechanism between agencies and/or government departments should be supported by written documentation of a referral pathway. This can be assisted by establishing focal points for referrals within each agency or each service within an agency.

Expectations about handling of case information must be discussed and procedures (often called Standard Operating Procedures or SOPs) for sharing information must be clearly agreed by all partners in a referral network to ensure that standards of confidentiality and safety are maintained at all times. With clear procedures and protocols in place, you can then discuss with children and caregivers which information they would like to share with different referral agencies and how they would like that information to be shared. You should clarify with the child and caregiver for how long this consent is valid. In some cases, consent may only be given for a one-off referral on the understanding that information about the case will not be shared after that particular referral has been made.

In situations of case transfer (for example when a child moves location or when an agency leaves and hands over children's cases to another agency or government department) the child's case file must NOT be handed over until the child/family has been contacted to ask whether they consent to the handover. The child/family may choose not to have their file handed over and may prefer not to receive any further support. This needs to be discussed clearly with the child and the family. You will also need to consider the child's best interest when deciding whether to transfer a case against the child's/family's wishes to ensure protection of the child. Transferring a child's case means that you and your organisation you are closing the case. The receiving agency will take on full responsibility for following and managing the child's case.

Remember, if service contracts or agreements are in place between your agency and various service-providers, you must monitor these agreements to ensure that the contract obligations are being met and that services are being provided in a timely and accountable manner.

CASE STUDY - Implementation of a case plan

Amina, a 16-year-old girl, came to Save the Children's Office one day after running away from school. Her parents had informed her that she was due to be married the next day to a forty-year-old man. She did not want to be married but they did not listen. Amina was very upset and did not know what to do. Save the Children discussed the options with Amina at length and it was agreed that she would make a report to the police.

The report was made and the husband-to-be and father arrested. Amina was taken to the Safe Haven for overnight shelter as it she would not be safe in the camps. The next day her father and husband presented themselves before the magistrate at the mobile court that visits Dadaab.

Save the Children provided a briefing for the Government Children's Officer who represented the case on the child's behalf. The husband to be was sentenced in court and the father released with a fine, as he showed remorse and was needed at home to support his family, including Amina, as she settled back into family life.

Amina joined a Children's Club of Save the Children and returned to school. She is very happy the situation was resolved quickly and without upsetting her family too much.

Save the Children Dadaab, GBV prevention and response Project, 2010.

STEP 5 - FOLLOW UP AND REVIEW

While part of the same step within the case management process, follow up and review have different purposes but the same objective; to make sure that the case plan is being implemented and that it continues to be relevant and meet the child's needs.

Follow up involves checking that a child and their family are receiving appropriate services and support to meet their needs, as outlined in the case plan, and checking that their situation is stable and progressing positively in line with the case plan. Follow up is carried

out regularly during the case management process, with the child and his/her family and other actors, to check that specific actions have been taken and services provided.

Examples of follow-up actions in line with the child's specific case:

- Checking the child received needed medical support
- Checking the child has registered for school
- Checking how mediation with parents has influenced their behaviour towards the child
- Checking that the child's relationship with the parents is improving
- Checking that the child continues to attend school
- Checking if the breathing techniques you taught the child to help them relax have helped.

Follow-up is essential to help caseworkers to find out if the case plan is working, and to identify any changes in a child or family's circumstances that might necessitate a review and change of the case plan. As part of follow up it is important to also consider whether any risk factors have increased. If so other urgent actions may be necessary.

Follow up can occur at any point from when the child is first registered and an initial intervention begins (responding to a child's immediate needs) until the child's case is closed. Once a case plan is developed the schedule of follow-ups can be recorded there. The frequency of follow ups will depend on the situation of the child, their specific needs and the risk level of the case. For example if children are placed in safe houses for a limited time, daily phone calls may be essential to check on the child's safety and wellbeing. The pattern and frequency may be adapted as the case progresses and the child's situation improves.

Follow-up can take place in a variety of ways. Some options you can consider include:

- Meetings with the child and / or family.
- Home visits - Before carrying out a home visit it is important to establish what the purpose of the visit is, and how the visit will be used to support the child and their family.
- Scheduled home visits – if appropriate, home visits may be part of the case plan for direct service delivery and follow-up. You must consider the repercussions of home visits to ensure that the child/family is not exposed to harm (for example by drawing the attention of neighbours/community to the child and their family).
- Ad hoc home visits - these can be particularly important for following-up the situation in the home and are useful when the home environment is volatile or levels of care are low. Ad-hoc home visits may provide a better opportunity to observe the child or to find the child alone if parents/caregivers have previously refused an individual interview.
- Phone calls - these may be necessary for care placements that need follow-up in the initial stages, and can be useful for children living in remote areas.
- Confirmation from relevant service provider that the child who was referred to their service actually received the service.
- Informal community-based follow-up, e.g. contacting the child's teacher if they are involved in supporting the child as part of the case plan, or follow-up through community groups.

Review of a case plan allows you to address changing situations and circumstances and to ensure that plans continue to be relevant and meet the child's needs.

A review should take place at least every three months, and more frequently in an emergency context, if the situation is changing rapidly or the risk level is high. It may be helpful for others involved in the case to also participate and for a supervisor or someone not directly involved in the case to chair the review.

Complex cases such as those managed over an extended period of time, or involving many actors in their implementation, may require multi-sector / inter-agency (as appropriate) reviews called 'case conferences', as discussed below.

Review of the case plan is usually done at strategic intervals to allow the caseworker, often together with their manager and the child / family, to see if the child's case is progressing towards the goals and specific objectives that had been set or whether the child requires additional or different services.

Monitoring is often used instead of the term 'follow-up' to describe the same function. For consistency, in these guidelines 'monitoring' is used to describe a function of Supervision and as a result only the term 'follow-up' is used in this section.

Case Management Fora

Three other types of meetings are useful for you to know about as these relate to planning and review. Often the terms 'case management meetings', "case planning meetings", and 'case conferences' are used interchangeably; however, they have different purposes.

Case planning meetings are internal agency meetings used to develop a case plan for an individual child. They include the participation of the child, parents/ caregivers (where appropriate), and caseworker. In complex cases, the caseworker's supervisor may also be present. Case planning meetings are essential for facilitating the child (and their parents') meaningful participation in the case management process.

Case management meetings are internal agency meetings held at regular intervals and involving managers/ coordinators/ supervisors (as appropriate) and caseworkers to review caseloads. They provide an opportunity to review all open cases, to compare how different cases are progressing, to discuss various types of response, to share lessons learned, to prioritize certain cases for immediate response, and to take joint decisions for complex cases. At these meetings, information shared on cases should be anonymous, discussing situations without reference to identifying information, and should be held in confidential locations. Children and their families do not take part in these meetings. In emergency contexts, these meetings should be held approximately once a week.

Case Conferences are more formal multi-sector / inter-agency case planning or review meetings for very complex cases. The purpose of a case conference is to explore multi-sector / inter-agency service options, and to make formal decisions in the best interest of the child. Case conferences should be documented with a report / minutes (see Appendix 10). The child and family participate in some (but not all) case conferences. Any participation would require careful planning and facilitation. The opinions and input of the child and family should always be sought in order to feed into decisions made.

TYPES OF CASE MANAGEMENT FORA			
	<i>Case Planning/ Review Meetings</i>	<i>Case Management Meetings</i>	<i>Case Conferences</i>
Purpose	Develop / review case plans	Reviewing caseloads/ supervision within one agency	Formal decision making and develop / review case plan
Which cases?	All	As decided by agency, cases are discussed anonymously	Complex cases where intervention is interagency, multi-disciplinary, or multi-sectorial
Participation of child and family?	Yes	No	Not usually, but possible if well planned/facilitated
Participation of other actors?	If needed and appropriate	No, within the agency between caseworkers & managers/ supervisors only	Yes – this is the purpose!

EXAMPLES OF CASE MANAGEMENT FORA

Case Planning Meeting	Case Conference	Case Management Meeting
<p>In Zimbabwe a legal aid organisation called CATCH works with children in conflict with the law, their extended family and government caseworkers to develop a case plan that outlines how they will be supported to not re-offend. This is then presented to court where a decision is made about whether to maintain the charge against the child or to 'divert' the child from the formal justice system, following the case plan instead.</p>	<p>UNHCR's Best Interests Determination panel is a formal process with strict procedural safeguards to guide particularly important decisions about a child's like. Key examples include removal of a child from harmful caregivers and deciding whether to resettle unaccompanied and separated children to third countries without their parents / previous primary caregivers. The panel usually includes multidisciplinary actors including educationalists, health workers, mental health workers, the case management agency, government caseworkers and UNHCR.</p>	<p>In Kenya, Child Line and government caseworkers hold daily case management meetings to review cases that have been called in overnight and that have been marked by telephone counsellors as urgent. The cases are allocated to caseworkers and updates on the previous day's cases are shared. Cases are all discussed anonymously using reference codes and a database.</p>

STEP 6 - CASE CLOSURE

The final step in a case management process is case closure. The specific criteria for when a case can be closed should be identified as part of the SoP.

Most often cases are closed when the goals of the child and family, as outlined in the case plan, have been met, the child is safe from harm, their care and well-being is being supported, and there are no additional concerns. Other reasons cases can be closed are:

- The family / child no longer want support and there are no grounds for going against their wishes (i.e. provided this is safe for the child)
- The child is turns 18 years old³²
- The child dies

Case management procedures require that the closure of the case be authorised by a manager. This ensures that cases are not closed prematurely.

32. When a child turns 18, it is important to prepare for this and support the child to identify what this means and where they can go to for continued support should this be required and/or wanted.

Cases should not be closed immediately after the plan has been concluded, but after a set period of time during which several monitoring visits take place to ensure the child's sustained well-being. After closure, a visit should take place within three months (often less in an emergency setting) to ensure that the situation remains stable and to seek feedback from the child and their family on the service provided.

Closure does not mean that all documentation is erased as cases can be reopened at any time whenever new information becomes available or the child's situation changes. A case may also be closed in the event of the death of the child, although an investigation should be done into the circumstances of the child's death to ensure that no other children are at risk. Any incident of child death should be reported to the government department responsible for child protection.

Closed cases should be stored in a safe place for a specific period of time in accordance with your agency's data protection protocol or national legislation.

Case Transfer

In some situations cases are not closed but are transferred to another agency. Often this happens when a child moves, but still needs a case plan to ensure their protection. Transfers also take place where the original caseworker or agency are no longer best placed to lead, manage and coordinate the handling of the child's case.

The transfer of a case indicates that the full responsibility for coordination of the case plan, follow up and monitoring of the child, is being handed over to another agency or department (as distinct from referral where these responsibilities remain with the original caseworker).

When transferring a case, you will need to put in place a clear plan for hand-over to the receiving agency, and clearly communicate this to the child and the family. Where possible the caseworker should accompany the child to meet the new caseworker who will take over the support.

Transfer of a child's case should be avoided unless it is absolutely necessary. If considering the transfer of a child's case, there must be good cause and a clear indication that the child will receive a better degree of service than they are currently receiving. Transferring children simply because their care needs are challenging is often not in the best interest of the child and can result in greater harm. Before transferring a case, you should consider that the more times a child is transferred, the greater the likelihood that the child will drop out of the care system and miss out on receiving needed services.

When transferring whole caseloads to another agency and/or the government, the process should include a review of all case files to confirm consent on sharing information where this is needed.



CASE STUDIES

CASE STUDY 1: Children's Participation in Case Management

Under the UN Convention on the Rights of the Child, 1989, children have a right to participate in decisions that affect their lives. Unfortunately, often this is not done, and children lose control over their lives and what happens. Feeling valued, and having a belief in their ability to make a difference, is extremely important in developing children's resilience. Resilience is a characteristic that helps a child strive and thrive, even in great adversity. As such it is an important quality for children to develop in order to grown into independent adults able to competently live in society.

This case illustrates that, even in difficult circumstances when the "perfect solution" cannot necessarily be found, children can still be empowered and included in decisions.

Case Background:

L (12 years old) lived with her adoptive parents. The adoptive parents had taken L from her biological parents when she was a baby through an informal agreement between the families, although this had never been legally formalised. The father worked as a security guard, while the mother suffered from a severe mental health problem and was often violent to her family and other members of the community. L attended school regularly and was referred by the school to CPU after L said that she was threatened by her mother and was afraid to go home.

Intervention:

As an initial and immediate response, given the apparent level of risk from the referral, the Child Protection Worker and police visited the home. During the encounter with the police officer, the mother became violent, threatened L and threw hot oil at the police officer.

L was immediately removed as it was clear that she would be unsafe in the house, and that the father could not protect her. Without any other alternatives, L was placed in a Residential Care Facility for an interim period until a comprehensive assessment could be completed and protection plan could be developed.

Shortly following the visit from the police and Child Protection Worker, the mother was hospitalised and the father took L back home. A few months later, the adoptive mother was released home but unfortunately immediately upon her release she became violent. The multidisciplinary team decided that given the risk L should return



to the Residential Care Facility. Sometime thereafter, the biological mother and sister (who the L had never met), as well as the adoptive father, jointly requested to remove L from the Residential Care Facility. The mother declared that she would like L to re-join her biological family and live with them.

Given the irregularities concerning the adoption process, the lack of proper documentation, the situation of the adoptive family and the limited relationship that L had with her biological family, it was decided by L and all members of the multidisciplinary group that she should remain at the Residential Care Facility, regularly attending school, while further investigations were carried out. It was felt that this would also give L more time to establish a relationship with her biological family and decide where she wanted to live.

The school psychologist, Child Protection Workers and social workers at the Residential Institution are closely following L, and providing all the possible psychosocial support. L has participated in the overall process of her case management and has taken an active part in all discussions and signed her approval on all decisions taken by the CPU and the multidisciplinary group. While her situation is far from ideal, L believes that she has some control over her life and future and knows that whatever happens to her will be based on her views.

Terre des Hommes. Case Management Experience from the Field: Case Studies from Albania.

CASE STUDY 2: Successful BID and reunification process

Save the Children in Kenya first came across Fatima³³, a 10 year old deaf-mute girl who was an unaccompanied child living in a transit centre in a refugee camp in Dadaab, Kenya, in October 2007.

When Fatima was separated from her family in Somalia three years earlier, a woman took Fatima under her foster care and look after her of her own free will. Fatima and the woman were registered in Save the Children's Child Protection Programme and under this programme Save the Children began a formal case management monitoring of the girl and her situation. They worked with UNHCR to conduct a Best Interest Determination Assessment and formalize the temporary care arrangement with the woman, which was approved by the local District Children's Office.

A year later, during a refugee relocation exercise, a relative of Fatima's biological mother recognized Fatima and alerted her mother. The mother, who was by now living in Nairobi, travelled to be re-united with Fatima and assume parental responsibility and care.

Despite the mother's eagerness to resume care for her daughter, it was necessary for her to verify that she was indeed Fatima's biological mother and to formalize the transfer of responsibility and care. Because the mother had no legal documents indicating that she was Fatima's biological mother, she could not prove her maternity.

However, Save the Children was able to corroborate the validity of her claim because the case history the mother reported of the child matched exactly that of Fatima's case history recorded in the agency's CP IMS database three years earlier. Using this information, UNHCR conducted a second BID Assessment and approved the reunification of Fatima with her family. The District Children's office formally recognized the reunification and granted custody to the biological mother, whom the child remains happily with to this day.

Save the Children. Child protection programme. Dadaab, Kenya

RESOURCES AND TOOLS

GBV	<ul style="list-style-type: none">❖ <i>Caring for Child Survivors of Sexual Abuse: guidelines for health and psychosocial service providers in humanitarian settings</i> (IRC, UNICEF, 2012)❖ <i>IASC Guidelines for Gender-Based Violence interventions in humanitarian settings</i>
CP	<ul style="list-style-type: none">❖ <i>Draft Case Management Handbook for Child Protection workers</i> (Tdh 2013)❖ <i>Field Handbook and training materials on UASC in emergencies</i>❖ <i>Field Handbook for the Implementation of UNHCR BID Guidelines</i>, (UNHCR, November 2011)

33. Name has been changed to protect the child's identity



APPENDICES FOR REFERENCE:

1. Competency and Skill Matrix for Case Management Staff

2. Roles of Supervisors vs. Caseworkers

3. Sample Child Protection/ Child Safeguarding Policy

4. Sample of registration forms

- a. UASC Inter Agency Registration Form
 - b. UASC Inter Agency Extended Registration Form
 - c. Sample of registration form
-

5. Samples of assessment forms

- a. Best Interest Assessment, UNHCR
 - b. Child Survivors Assessment, IRC/UNICEF
 - c. Assessment report on the situation of the child, Tdh
-

6. Risk assessment guide

7. Sample of Case Planning forms

8. Sample of Follow up Form

9. Sample of Case Conference report

10. Sample of Case Closure Form

11. Sample of Case Transfer Form

12. Sample of Data Protection Policy

13. Sample of informed consent

14. Sample of guidance note for informed consent

■ APPENDIX 1: CASEWORKER COMPETENCY AND SKILL FRAMEWORK³⁴

Skills	Competencies
Personal Competencies	
Know and question yourself	- Know your strengths, weaknesses and resources; question and assess yourself to develop skills; critically reflect upon your performance using supervision.
Manage stress and emotions	- Listen to and express feelings and emotions in an appropriate way; know your signs of stress; learn to manage stress to release tension and act effectively; use supervision to talk about stress and your work.
Be flexible and open to change, adapt to cultural differences	- Cultural sensitivity (1): work effectively with people from all backgrounds, avoid stereotypical responses by examining own behaviour and bias, show an openness and interest in learning about cultures.
Analyse, think in a critical and creative way and make decisions	- Find creative solutions and show initiative. - Problem solving (1): examine difficult issues from different perspectives. - Decision making (1): gather relevant information before making decisions, check assumptions against facts; Make decisions regarding own workload and area of responsibility.
Be accountable and work with integrity	- Integrity (1): do not abuse your own power or position, resists undue political pressure in decision-making, show consistency between expressed principles and behaviour, act without consideration of personal gain. - Accountability (1): operate in compliance with accountability principles and codes of conduct, show respect for beneficiaries, take responsibilities for actions and honour commitments, ensure openness and transparency.

34. Adapted from Tdh Case Management Handbook for Child Protection Workers 2013 (draft) and the Inter-agency Child Protection in Emergencies Competency Framework (2010) Child Protection Working Group (the title and level is provided when these competencies are used).



Social Competencies	
Negotiate and manage problems and conflicts	<ul style="list-style-type: none"> - Negotiating (1): apply the principles of negotiation aiming for a 'win'-win' outcome, adapt style to take account of cultural differences regarding negotiation, present or propose alternative ways of doing things to others. - Problem solving (1): deal with problems as they occur, support others in solving problems. - Advocate on child protection issues (1): express differences in opinion in a sensitive and controlled manner, illustrating tact when dealing with others.
Work and coordinate within a team or network	<ul style="list-style-type: none"> - Work with colleagues to contribute to team development; respect others' opinions; promote their skills with joint action; give and receive constructive feedback.
Show empathy, warmth and genuineness	<ul style="list-style-type: none"> - Empathy (2): expand sense of concern for oneself to others, responding in a way that is in line with their emotional and physical state. - Cultural sensitivity (1): act in a non-discriminatory way.
Support and motivate a person / a group	<ul style="list-style-type: none"> - Recognize and handle emotionally sensitive issues. - Adapt working style to the child and the family; work alongside them lead them towards a common goal; create and maintain their motivation.
Communicate and listen to others	<ul style="list-style-type: none"> - Communication (1): express oneself verbally in a clear and coherent manner; listen actively to others, reflecting back what is said; tailor tone, style and format to match the audience, particularly cross-culturally; overcome barriers due to language. - Build trust (2): create and maintain an environment in which others can talk and act without fear of repercussion. - Cultural sensitivity (1): treat all people with fairness, respect and dignity. - Promote children's participation and agency (1): address children in a friendly manner that shows respect, and ensure the timing and environment are conducive to effective communication; use language at an appropriate level of clarity and friendliness when communicating with children; understand the barriers and challenges affecting children's participation, including possible security and protection risks, and perceptions of it in different contexts; understand and describe / share the benefits of children's participation in decisions that affect them.

Methodological Competencies	
Promote participation and cooperation in case management	<ul style="list-style-type: none"> - Encourage children and families to take part in the identification of their needs and resources during assessment; work with them to help them make informed decisions throughout the case management process. ; actively involve stakeholders and encourage participation - Understand the importance of coordination among service providers to deliver holistic support to children.
Plan, implement, review the intervention	<ul style="list-style-type: none"> - Produce, implement and review case plans with children, families and others as appropriate. - Know how to help families provide appropriate support to their children. - Understand barriers families face to accessing services.
Technical Competencies	
Know the theoretical framework needed for working with children and families	<ul style="list-style-type: none"> - Know and understand the local context including: child development in the context; relationship dynamics within the context; and cultural practices impacting on child welfare. - Understand protection concerns for children (2): good knowledge of: indicators for and consequences of abuse, neglect, exploitation and violence on children; core theories related to child care and protection; how to identify factors that increase vulnerability and risk, and reduce resilience in different situations and during different stages of development. - Understand child protection programming (1): Understand: the main principles and approaches to child protection programming; that child protection is a sector in its own right; linkages with other sectors; the basic roles and responsibilities of agencies involved with safeguarding children. - Use a rights-based approach in child protection (1): Basic knowledge of national and international legal frameworks and conventions relating to child care and protection including the UNCRC; the challenges associated with addressing children's rights holistically with limited time / resources. - Understanding Protection Concerns for Children (1): Implement measures to ensure that confidential information and sensitive documents are kept safely; ensure colleagues comply with UN standards on sexual exploitation and abuse and organisational codes of conduct; ensure breaches of confidentiality are addressed with immediate effect
Have the specific tools for case management	<ul style="list-style-type: none"> - Know the tools and processes required for service mapping, documenting the case management, information management, data protection, information sharing, and working with others in case management.



■ APPENDIX 2: ROLES OF SUPERVISORS VS. CASEWORKERS

Requirements of Caseworkers	Requirements of Managers & Supervisors
Identify individual cases through regular presence in the community and accept referrals from other agencies and community partners.	Schedule and supervise case management meetings at least every two weeks. Share minutes of case management meetings with team and senior CP management.
Conduct initial (rapid) assessments for CP cases and prioritize them according to risk level.	Conduct weekly supervision meetings with all caseworkers, providing technical advice on cases and psychosocial support to caseworkers. Facilitate peer-to-peer support groups where appropriate.
Develop case plans that respond to needs addressed in initial and comprehensive assessments and seek support of supervisor when necessary.	Support individual cases where required and provide regular monitoring of all aspects of case management services.
Regularly follow up to ensure all services and action points listed in the case plan are carried out within agreed time frames. Ensure that progress is regularly reviewed.	Ensure staff gaps and training needs do not result in gaps in support to individuals in case management, and address such issues with senior management.
Regularly monitor and support to children and families through home visits, providing guidance, advice and emotional support, community mediation and referrals.	Review staff case loads to ensure they are manageable and share challenges with senior management.
Work with supervisors and managers to arrange case conferences for complex cases and ensure children receive multi-disciplinary support.	Monitor timescales for response, decision-making, placement, follow-up and review.
Manage cases in line with SOPs, adhere to standard documentation processes and follow best practice guidance.	Ensure access to material, logistical, and further technical support and set eligibility criteria for material and other support.
Regularly document cases using case notes and other agreed upon forms, update databases to ensure a comprehensive record of the case.	Review and analyse trends in the caseload to inform programming.
Ensure that data collection and storage respect data protection protocols and confidentiality principle.	Conduct regular case file audit and check that protocols and principles are respected.

■ **APPENDIX 3: SAMPLE OF CHILD PROTECTION/CHILD SAFEGUARDING POLICY**³⁵

Save the Children:

Child Protection Policy



³⁵. Child Protection Policy. Save the Children. 2003



The International Save the Children Alliance is the world's leading independent child rights organisation with members in 29 countries and operational programmes in more than 100.

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Vision

Save the Children works for:
a world which respects and values each child
a world which listens to children and learns
a world where all children have hope and opportunity

Mission

Save the Children fights for children's rights.
We deliver immediate and lasting improvements
to children's lives worldwide

Introduction

States Parties shall protect the child from all forms of physical or mental violence, injury or abuse, neglect, maltreatment or exploitation, including sexual abuse. (UN Convention on the Rights of the Child (1989), Article 19)

Members of the International Save the Children Alliance have a common commitment to the prevention of child abuse and the protection of children. The abuse and exploitation of children happens in all countries and societies across the world.

This policy sets out common values, principles, and beliefs and describes the steps that will be taken in meeting our commitment to protect children.

The policy was adopted by the International Save the Children's Member's Meeting May 2003.



Our commitment to protect children

Our values, principles and beliefs

- All child abuse involves the abuse of children's rights.
- All children have equal rights to protection from abuse and exploitation.
- The situation of all children must be improved through promotion of their rights as set out in the UN Convention on the Rights of the Child. This includes the right to freedom from abuse and exploitation.
- Child abuse is never acceptable
- We have a commitment to protecting children with/ for whom we work
- When we work through partners, they have a responsibility to meet minimum standards of protection for children in their programmes.

What we will do

We will meet our commitment to protect children from abuse through the following means:

Awareness: we will ensure that all staff and others are aware of the problem of child abuse and the risks to children.

Prevention: we will ensure, through awareness and good practice, that staff and others minimise the risks to children.

Reporting: we will ensure that staff and others are clear what steps to take where concerns arise regarding the safety of children.

Responding: we will ensure that action is taken to support and protect children where concerns arise regarding possible abuse.

In order that the above standards of reporting and responding are met, members of the International Save the Children Alliance will also ensure that they:

- take seriously any concerns raised
- take positive steps to ensure the protection of children who are the subject of any concerns
- support children, staff or other adults who raise concerns or who are the subject of concerns
- act appropriately and effectively in instigating or co-operating with any subsequent process of investigation
- are guided through the child protection process by the principle of 'best interests of the child'
- listen to and takes seriously the views and wishes of children
- work in partnership with parents/carers and/or other professionals to ensure the protection of children.

How we will ensure our commitments above are met

- All International Save the Children Alliance staff (locally appointed and internationally appointed) will sign up to and abide by the attached code of conduct
- All partners will sign and abide by the code of conduct
- All staff and volunteers will have access to a copy of the child protection policy
- Recruitment procedures will include checks on suitability for working with young people
- Induction will include briefing on child protection issues
- Every workplace will display contact details for reporting possible child abuse and every member of staff will have contact details for reporting.
- Systems will be established by every Member to investigate possible abuse once reported and to deal with it
- Training, learning opportunities and support will be provided by Save the Children members as appropriate to ensure commitments are met.



Code of conduct

All Save the Children staff must sign up to and abide by this Code of Conduct.

Staff and others must never:

- hit or otherwise physically assault or physically abuse children
- develop physical/sexual relationships with children
- develop relationships with children which could in any way be deemed exploitative or abusive
- act in ways that may be abusive or may place a child at risk of abuse.
- use language, make suggestions or offer advice which is inappropriate, offensive or abusive
- behave physically in a manner which is inappropriate or sexually provocative
- have a child/children with whom they are working to stay overnight at their home unsupervised
- sleep in the same room or bed as a child with whom they are working
- do things for children of a personal nature that they can do for themselves
- condone, or participate in, behaviour of children which is illegal, unsafe or abusive
- act in ways intended to shame, humiliate, belittle or degrade children, or otherwise perpetrate any form of emotional abuse
- discriminate against, show differential treatment, or favour particular children to the exclusion of others.
- This is not an exhaustive or exclusive list. The principle is that staff should avoid actions or behaviour which may constitute poor practice or potentially abusive behaviour.

It is important for all staff and others in contact with children to:

- be aware of situations which may present risks and manage these
- plan and organise the work and the workplace so as to minimise risks
- as far as possible, be visible in working with children
- ensure that a culture of openness exists to enable any issues or concerns to be raised and discussed
- ensure that a sense of accountability exists between staff so that poor practice or potentially abusive behaviour does not go unchallenged
- talk to children about their contact with staff or others and encourage them to raise any concerns
- empower children - discuss with them their rights, what is acceptable and unacceptable, and what they can do if there is a problem.

In general it is inappropriate to:

- spend excessive time alone with children away from others
- take children to your home, especially where they will be alone with you.

■ APPENDIX 4: SAMPLES OF REGISTRATION FORMS

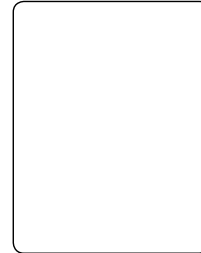
A. UASC INTER AGENCY REGISTRATION FORM

Inter-Agency Working Group
on Unaccompanied and Separated Children

REGISTRATION FORM

NOTE: The shaded areas of the form are for you to complete without asking directly these questions to the child.

Does the child understand why the information is collected, how it will be used and agrees to be registered? yes no



1 Data Confidentiality

Have you re-explained to the child what the information will be used for and what the process will be? yes no

Does the child/caregiver agree to the public disclosure (on posters, radio, Internet, etc.) of his/her:

a. name yes no	b. photo yes no	c. names of relatives yes no
--------------------------	---------------------------	--

(Explain how information will be made public, how their identity will be kept confidential and how sharing information may increase chances of successful tracing)

Specify what information should be withheld:

Additional information (state if permission given by caregiver):

Does the child agree that the information collected can be shared with:

a. Family yes no	b. Authorities yes no	c. Other Organizations yes no
----------------------------	---------------------------------	---

d. Others yes no Specify who:

Reason for withholding information (can select multiple) fear of harm to themselves or others

Want to communicate information themselves Other reason - specify:

Additional information (state if permission given by caregiver):

Signature of child: and/or (optional) caregiver:

2 Child's Personal Details

Registration ID (generated by the database):

Other Agency ID (No.): Name of Agency:

Personal ID document (Type and No.):

Is the child: Separated Or Unaccompanied Urgent protection concern yes no

Child's First name Second name Third name

Nickname Other name (after separation) Sex: F M

Age: Estimated: yes no Birth date:

Nationality: Religion: Languages:

Arrival date: Description:



Address before separation: Country: Region: District:
 Village: Street: Landmarks:
 Description:

Current address: Country: Region: District:
 Village: Street: Landmarks:

Telephone Number:

Distinguishing Physical Characteristics (eg birthmarks of visible disabilities):.....

3 Wishes of the Child

If the child DOES want family reunification: adults child wishes to locate

1st preference: Relationship:
 First name: Second name: Third name:

Last known address: Country: Region: District:
 Village: Street: Landmarks:

Telephone Number:

Does the child wish to continue in the current care arrangement? yes no If No, why:

Type of care arrangement child wishes to have:

Independent living	Alternative interim care
With Husband/wife/partner	Don't know
Other family	

4 Family Details

Who was the child living with before separation: Father Mother Other:

Father's First name: Second name: Third name:
 Is father alive? yes no don't know

Mother's First name: Second name: Third name:
 Is mother alive? yes no don't know

Name of Caregiver (other) before separation (if not mother or father)
 First name: Second name: Third name:
 Relationship: Is caregiver before separation alive? yes no don't know

Family members (adults or children) child is separated from (other than those named above):

A. First name: Second name: Third name:
 Relationship: Sex F M Alive: yes no don't know Occupation:

B. First name: Second name: Third name:
 Relationship: Sex F M Alive: yes no don't know Occupation:

C. First name: Second name: Third name:
 Relationship: Sex F M Alive: yes no don't know Occupation:

Family members/other important persons child is with (adults or children):

First Name	Second Name	Third name	Relationship	Database ID	Other ID	Sex (F/M)	Age
.....
.....
.....
.....
.....

5 Current care arrangements

What are the child's current care arrangements?

Residential Care Centre Stays with related caregiver Stays with unrelated caregiver
 Independent Living Child Headed Household Lives with peers/other children
 Other (Please specify):

Name of current caregiver: Relationship of this person to the child:
 ID Type and No: Age: Contact details (telephone):

6 History of Separation

Date of separation:

Place of separation: Country:..... Region:..... District:.....
 Village: Street: Landmarks:

NOTE: the below must not be asked as direct question but through general dialogue with the child or if they are raised by the child directly

7 Protection Concerns

Is there any urgent/immediate concern the child would like to raise?

Protection Concerns (Tick all that apply):

<input type="checkbox"/> Sexually Exploited	<input type="checkbox"/> Disabled	<input type="checkbox"/> Physically or Mentally Abused
<input type="checkbox"/> GBV survivor	<input type="checkbox"/> Serious Health issue	<input type="checkbox"/> Living with vulnerable person
<input type="checkbox"/> Trafficked/smuggled	<input type="checkbox"/> Refugee	<input type="checkbox"/> Worst Forms of Child Labor
<input type="checkbox"/> Statelessness	<input type="checkbox"/> CAAFAG	<input type="checkbox"/> Child Headed Household
<input type="checkbox"/> Arrested/Detained	<input type="checkbox"/> Street Child	<input type="checkbox"/> Mentally Distressed
<input type="checkbox"/> Migrant	<input type="checkbox"/> Child Mother	<input type="checkbox"/> Other

Please provide more information where possible

Other (please specify)

Assessment: urgent intervention ongoing monitoring no further action needed

If further intervention is required, by when (date):

8 Details of Interviewer

Name: Signature:

Position: Agency: Date:

Location of interview: Country:..... Region:..... District:.....
 Village: Street: Landmarks:

Information obtained from: child caregiver other (specify):.....



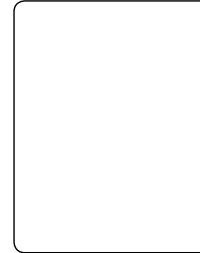
B. UASC INTER AGENCY EXTENDED REGISTRATION FORM

Inter-Agency Working Group
on Unaccompanied and Separated Children

EXTENDED REGISTRATION FORM

NOTE: The shaded areas of the form are for you to complete without asking directly these questions to the child.

Does the child understand why the information is collected, how it will be used and agrees to be registered? yes no



Who referred the child to the caseworker?

Has the child been interviewed by another organisation? yes no Please Specify:

Place of previous interview..... Date:

(NOTE: If child has already been interviewed by another organisation, only collect additional information but do not ask the same questions again)

1 Data Confidentiality

Have you re-explained to the child what the information will be used for and what the process will be? yes no

Does the child/caregiver agree to the public disclosure (on posters, radio, Internet, etc.) of his/her:

a. name yes no b. photo yes no c. names of relatives yes no

(Explain how information will be made public, how their identity will be kept confidential and how sharing information may increase chances of successful tracing)

Does the child agree that the information collected can be shared with: a. Family yes no b. Authorities yes no

c. Other Organizations yes no d. Others yes no Specify who

Specify what information should be withheld:

Reason for withholding information (can select multiple): fear of harm to themselves or others
Want to communicate information themselves Other reason Specify:

Additional information (state if permission given by caregiver):

Signature of child: and/or (optional) caregiver:

2 Child's Personal Details

Registration ID (generated by the database):

Other Agency ID (No.): Name of Agency:

Personal ID document (Type and No.):

Is the child: Separated Or Unaccompanied Urgent protection concern yes no

Distinguishing Physical Characteristics (eg birthmarks of visible disabilities):.....

Child's First name **Second name** **Third name**
Nickname (also known as) **Other name** (after separation) **Sex:** F M
Age: **Estimated:** yes no **Birth date:**
Nationality: **Place of Birth:** **Country:**
Ethnic Affiliation: **Religion:** **Arrival Date:**
Address before separation: Country: Region: District:
Village: Street: Landmarks:
Telephone Number:
Description:
Current address: Country: Region: District:
Village: Street: Landmarks:
Telephone Number:

3 Wishes of the Child

Does the child want to trace family members? yes no
If the child DOES want family reunification, adults child wishes to locate:
1st preference: Relationship:
First name: Second name: Third name:
Last known address: Country: Region: District:
Village: Street: Landmarks:
Telephone Number:
2nd preference: Relationship:
First name: Second name: Third name:
Last known address: Country: Region: District:
Village: Street: Landmarks:
Telephone Number:
If the child does NOT want family tracing, explain why:
.....
Does the child want family reunification? Yes, as soon as possible Yes but later Not sure No
if 'No', 'Not sure' or Yes, but later', explain why:
.....
Does the child wish to continue in the current care arrangement? yes no If No, why:
.....
Type of care arrangement child wishes to have:
Independent living Alternative interim care
With Husband/wife/partner Other family Don't know
Other (please specify):
Where does the child wish/plan to live? Country: Region:
District: Village: Street: Landmarks:



APPENDICES FOR REFERENCE:

Give any other information of relevance that may assist with tracing for the child (such as key persons/locations in the life of the child who/ which might provide information about the location of the sought family – ex. names of religious leader, market place, etc.)
Please ask the child where he/she thinks his/her relatives, including siblings might be or whether the child is in contact with any family friend (include as well any useful information the caregiver might provide)

.....

List details of any documents carried by the child:

.....

4 Family Details

Who was the child living with before separation: Father Mother Other (please specify):

Father's First name: Second name: Third name:
 Is father alive? yes no don't know Profession/Occupation

Last known address: Country: Region: District:
 Village: Street: Landmarks:
 Telephone Number:

Mother's First name: Second name: Third name:
 Is mother alive? yes no don't know Profession/Occupation

Last known address: Country: Region: District:
 Village: Street: Landmarks:
 Telephone Number:

Is the child still in contact with his/her parents? yes no If yes, with whom:
 If yes, when was the last contact (date): and how?

If father/mother believed dead, give details, including whether information has been verified:

Name of Caregiver (other) before separation (if not mother or father)

First name: Second name: Third name:
 Relationship: Is caregiver before separation alive? yes no don't know

Last known address: Country: Region: District:
 Village: Street: Landmarks:

Is the child in contact with his/her caregiver? yes no
 If yes, when was the last contact (date): and how?

Family members (adults or children) **child is separated from** (other than those named above):

A. First name: Second name: Third name:
 Relationship: Sex: F M alive? yes no don't know Occupation:

Last known address: Country: Region: District:
 Village: Street: Landmarks:
 Date of Separation: Comments:

B. First name: Second name: Third name:
 Relationship: Sex: F M alive? yes no don't know Occupation:
Last known address: Country: Region: District:
 Village: Street: Landmarks:
 Date of Separation: Comments:

C. First name: Second name: Third name:
 Relationship: Sex: F M alive? yes no don't know Occupation:
Last known address: Country: Region: District:
 Village: Street: Landmarks:
 Date of Separation: Comments:

Family members/other important persons child is with (adults or children):

NOTE: these are different from the current care giver, whose information is collected below in section 5.
 If the child is travelling with other separated or unaccompanied children, a separate registration form will need to be completed for each UASC

First Name	Second Name	Third name	Relationship	Database ID	Other ID	Sex (F/M)	Age
.....
.....
.....
.....

What is the child's intended address:

Country: Region: District:
 Village: Street: Landmarks:

5 Current care arrangements

What are the child's current care arrangements?

Residential Care Centre	Stays with related caregiver	Stays with unrelated caregiver
Independent Living	Child Headed Household	Lives with peers/other children
	Other (Please specify):	

Name of agency providing or supporting care arrangement (if applicable):

Current caregiver: First name: Second name: Third name:
 Relationship to the child: ID Type and No: Age:
 Contact details (telephone): When did this care arrangement start?:

If current address is temporary, where does caregiver plan to live (repatriate, move, etc):

Country: Region: District:
 Village: Street:

Is caregiver willing to continue taking care of the child? yes no If yes, for how long:

Does the caregiver know the family of the child? yes no

Give any information that the caregiver may provide on the child and his/her family:

6 History of Separation

Date of separation (approximate if child does not know exact date):

Place of separation: Country: Region: District:
 Village: Street: Landmarks:



Describe the circumstances of separation:

.....

Describe additional movements between place of separation and current location:

.....

Did the child face or witness any type of violence, threat or harm during his/her journey?

.....

What was the main cause of separation? (Tick all that apply)

<input type="checkbox"/> Conflict	<input type="checkbox"/> Poverty	<input type="checkbox"/> Abandonment
<input type="checkbox"/> Death	<input type="checkbox"/> Natural Disaster	<input type="checkbox"/> Repatriation
<input type="checkbox"/> Family abuse/violence/exploitation	<input type="checkbox"/> Sickness of family member	<input type="checkbox"/> Population movement
<input type="checkbox"/> Lack of access to services/support	<input type="checkbox"/> Entrusted into the care of an individual	<input type="checkbox"/> Migration
<input type="checkbox"/> CAAFAG	<input type="checkbox"/> Arrest and detention	<input type="checkbox"/> Divorce/remarriage
<input type="checkbox"/> Other (please specify):		

NOTE: the below must not be asked as direct question but through general dialogue with the child or if they are raised by the child directly

7 Protection Concerns and related follow up action required

Is there any urgent/immediate concern the child would like to raise?

Protection Concerns (Tick all that apply):

<input type="checkbox"/> Sexually Exploited	<input type="checkbox"/> Disabled	<input type="checkbox"/> Physically or Mentally Abused
<input type="checkbox"/> GBV survivor	<input type="checkbox"/> Serious Health issue	<input type="checkbox"/> Living with vulnerable person
<input type="checkbox"/> Trafficked/smuggled	<input type="checkbox"/> Refugee	<input type="checkbox"/> Worst Forms of Child Labor
<input type="checkbox"/> Statelessness	<input type="checkbox"/> CAAFAG	<input type="checkbox"/> Child Headed Household
<input type="checkbox"/> Arrested/Detained	<input type="checkbox"/> Street Child	<input type="checkbox"/> Mentally Distressed
<input type="checkbox"/> Migrant	<input type="checkbox"/> Child Mother	<input type="checkbox"/> Other

Please provide more information where possible

Recommended follow up action/referral: ongoing monitoring no further action needed urgent intervention If intervention required, by when (date):

Services required	Officer/Agency	Comments
<input type="checkbox"/> Medical assistance
<input type="checkbox"/> Psychosocial support
<input type="checkbox"/> Education
<input type="checkbox"/> BID or BIA / Care-Plan required
<input type="checkbox"/> NFI/Clothes/Shoes
<input type="checkbox"/> Water/Sanitation
<input type="checkbox"/> Care arrangement review/change
<input type="checkbox"/> Refer to Refugee Registration
<input type="checkbox"/> Food
<input type="checkbox"/> Other

8 Details of Interviewer

Name: Signature:

Position: Agency: Date:

Location of interview: Country: Region: District:

Village: Street: Landmarks:

Information obtained from: child caregiver other (specify):

C. GENERIC SAMPLE OF REGISTRATION FORM³⁶

Compete only after Consent Form	
Registration Date DD/MM/YY: ___/___/___ Location: _____ Reference Code: _____	
Personal Information	
Full Name:	Age: Date of Birth (DD/MM/YY): ___/___/___
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Place of Birth:
Address:	Previous Address if Displaced:
Contact Details of Child (if applicable)	Contact Details of Caregiver (state name)
Family / Caregivers:	
<i>Living with Family</i> Both parents: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> (Step) Father's Name: <input type="checkbox"/> (Step) Mother's Name: <i>Circle if step.</i>	<i>Living with relatives</i> Head of Household Name: Type of Relation: Did the child know them before?
<i>Living with adult caregiver(s)</i> Name(s): How does the child know the caregiver(s)?	<i>Living with other children (under 18s):</i> Name(s):
Protection Concerns Described at Point of Identification / Referral (if referral state source of referral)	
Risk Rating: <input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low	If Low Date for Assessment (DD/MM/YY): ___/___/___
Caseworker Code:	Signature: _____ Date (DD/MM/YY): ___/___/___

36. Adapted from 2011IA CP IMS

APPENDIX 5: SAMPLES OF ASSESSMENT FORMS

A. SIMPLIFIED BEST INTERESTS ASSESSMENT³⁷

		<h1>RAPID BIA FORM</h1>	
UNHCR / PARTNER LOCATION / COUNTRY:			
		PRIORITY OF CASE / FOLLOW-UP: URGENT / NORMAL	
BIODATA		UNHCR ProGres/Registration No:	CP Case No:
Name of child:	DOB:		
Date of interview:	POB:		
Name of mother:	CoO and ethnicity:		
Name of father:	Date of entry CoA:		
Name of caregiver:	Gender:		
Religion:	Telephone number and/or address:		
Consent: Does the Child understand the reason for the BIA/BID interview and consent to continue the process? YES <input type="checkbox"/> NO <input type="checkbox"/>			
Prior Interview: Has a BIA/BID previously been conducted for the Child? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, details: Agency/Date/Location?			
History of flight/separation	Referral required:	Person to follow up:	
	Action:		
Brief summary of separation:			
Location/status of mother:		Tracing: Child's consent given?	
Location/status of father:		Tracing: Request for who?	
Siblings: <i>(indicate full name, age, gender and location)</i>		Other Relatives of importance: <i>(name relationship, age, gender and location)</i>	
1.		1.	
2.		2.	
3.		3.	
4.		4.	
Care Arrangement	Referral required?	Person to follow up:	
	Action:		
Caregiver Registration Number:	Date of home visit:		
Do the caregiver and child share a biological relation:	If yes, explain:		
<i>How long has the child lived here? How does the child describe the care situation, are there any concerns?</i>			
<i>What are the daily activities of the child (playing, household chores, school etc)? Does the child have friends? If not, why?</i>			
List all household members: <i>(name, relationship to caregiver, age, and gender.)</i>			
1.		4.	
2.		5.	
3.		6.	

37. Field Handbook and training materials for the implementation of the UNHCR Guidelines on Determining the Best Interests of the Child. UNHCR, 2011

Protection:	Referral required?	Person to follow up:
	Action:	
Does the child feel safe? Report any specific protection concerns, if so, please explain:		
If there is a concern, has the child reported it to any other person/agency and what action was taken?		

Psychosocial:	Referral Required?	Person to follow up:
	Action:	
How is the child feeling in terms of their overall happiness/well-being? What are the good and bad influences in their life?		
Who does the child talk to about their problems or ask for help (family, friends, community etc)?		

Education:	Referral Required?	Person to follow up:
	Action:	
Detail child's education background and needs:		

Health:	Referral Required?	Person to follow up:
	Action:	
Does the child report any specific medical concerns, if so, please explain:		
If the child currently taking any medications, if so please detail:		

Shelter / material needs:	Referral Required?	Person to follow up:
	Action:	
Detail child's current shelter and material needs (CRI / NFI):		

Other / Assessor Notes:	Referral Required?	Person to follow up:
	Action:	
Is there any other information the child or assessor would like to note?		

Referrals: <i>Mark 'X' all that apply.</i>				
BID	Tracing	Care Arrangement	Home Visit	Registration
Protection	Psychosocial	Education	Health	Shelter / material needs
Other (specify):				

Signatures:			
Name of assessor:	Organization:	Signature:	Date:
Name of supervisor:	Organization:	Signature:	Date:



B. SAMPLE OF ASSESSMENT FORM FOR CHILD SURVIVORS OF SEXUAL ABUSE³⁸

Incident ID: <input style="width: 90%;" type="text"/>	Survivor Code: <input style="width: 90%;" type="text"/>
Child Needs Assessment and Case Action Plan	
A. CHILD SAFETY ASSESSMENT	
Main Assessment Point: The child's current safety status.	
<input type="checkbox"/> Yes, the child is safe. <input type="checkbox"/> No, the child is not safe.	
Please explain in the box.	The following safety risks have been identified: <ul style="list-style-type: none"> <input type="checkbox"/> Child's caregivers cannot or will not protect the child from further abuse. <input type="checkbox"/> The perpetrator lives with the child/can easily access the child at home. <input type="checkbox"/> The child is fearful of family members and does not want to return home. <input type="checkbox"/> Other reason (please identify) _____
SAFETY ACTION PLAN	
Child Safety Plan Describe safety plan here.	
Safety Referral Made? <input type="checkbox"/> Yes <input type="checkbox"/> No	
IF YES Child client is referred to: Child will be accompanied by (describe by relationship e.g., Mother)	IF NO Why not?
B. CHILD HEALTH NEEDS ASSESSMENT	
Main Assessment Point: Does the child require a health referral?	
<input type="checkbox"/> Yes, a health referral is needed because:	
<input type="checkbox"/> Last incident was within the past 120 hours <input type="checkbox"/> Child complains of physical pain and injury <input type="checkbox"/> Other reason indicated (e.g. bleeding or discharge or is requested by survivor)	<input type="checkbox"/> No, a referral is not needed because: <input type="checkbox"/> Services already received from another agency <input type="checkbox"/> Service not applicable (e.g. abuse did not involve contact) <input type="checkbox"/> Other reason:
HEALTH ACTION PLAN	
Health Referral Made? <input type="checkbox"/> Yes <input type="checkbox"/> No	
HEALTH REFERRAL NEEDED, BUT NOT MADE BECAUSE:	
<input type="checkbox"/> Referral declined by survivor <input type="checkbox"/> Service Unavailable <input type="checkbox"/> Referral refused by caregiver <input type="checkbox"/> Non-urgent referral made	
IF YES Child client is referred to: Child will be accompanied by	Explain:
Note: In cases of medical emergency, it is in the child's best interest to receive life-saving care. If a caregiver or child refuses the referral, a supervisor must be contacted immediately and/or a referral made if the child's life is at risk.	

38. Implementation Guidelines. Caring for Child Survivors of Sexual Abuse in Humanitarian Aid Setting. IRC. 2011

Incident ID: _____

Survivor Code: _____

C. CHILD PSYCHOSOCIAL NEEDS ASSESSMENT
Main Assessment Point: The child's current emotional state and level of functioning.

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

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

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

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

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

PSYCHOSOCIAL ACTION PLAN

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

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

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

D. CHILD LEGAL NEEDS ASSESSMENT AND ACTION PLAN

Legal Referral Made? Yes No

If NO, why not?

If YES
Child client is referred to:

Child will be accompanied by

E. CASE ACTION PLAN REVIEW AND FOLLOW-UP MEETING

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

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

All relevant consent forms for referral signed: Yes No

If not, explain why here:

Follow up meeting is scheduled for: Date: _____ Location: _____



C. GENERIC SAMPLE OF ASSESSMENT FORM³⁹

ASSESSMENT REPORT ON THE SITUATION OF THE CHILD
Name of the child:
Reference worker:
Tdh registration number and date:
Reason for referral /assessment:
Assessment period: from.....to.....
List of people having taken part in the assessment and their function/role:
.....
.....
.....
SITUATION OF THE CHILD
Child's development: observation of psychological, emotional, intellectual and social attitude also comprising difficulties (speech, communication, inattention, aggressiveness, lack of understanding and concentration, etc.)
Child's health and physical development: size weight, deficiencies, handicap through accident or from birth, illnesses
Integration into family and interactions with siblings, parents: observation of relationships (particular behavior with one or the other person, fear, shyness...)
Integration into society: educational activities, recreational activities, observation from neighbors , etc.
Views / Wishes of Child regarding the situation
CARE GIVERS/ CHILD SITUATION
Relationship between adults in the household and their behavior with the child (Parenting Capacity: taking into account the ability of the parents / care givers to protect the child and to meet their needs, and the way in which the family functions)

39. Case Management Handbook for Child Protection Workers, Tdh, 2013

<p>Living Conditions & Economic / Employment Situation: (This should include housing, number of bedrooms, sanitation, electricity, water, size, furniture, food, sources of income, family income /resources))</p>																
<p>Support from Extended Family / Community</p>																
<p>Views / Opinions of Parents / Caregivers</p>																
<p>OTHERS PROFESSIONALS OPINIONS</p>																
<p>Opinions of other professionals (This should be used to record information collected from all the professionals who have been in contact with the child or other family member who is not registered elsewhere. Could be information on reports of domestic violence to the police, reports of drunkenness on the street, etc.).</p>																
<p>CONCLUSIONS OF CHILD PROTECTION WORKER</p>																
<p>Opinions and observations of the CPW (includes the observations on the child, attitudes and support for parents / guardians during the evaluation</p>																
<p>Identification of main risks and protection factors Main risk factors (at the level of the child, the family and the wider community)</p> <p>Risk level from 1 to 3:</p> <table border="0"> <thead> <tr> <th></th> <th>Low</th> <th>Medium</th> <th>High</th> </tr> </thead> <tbody> <tr> <td>1.....</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>2.</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>3.....</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </tbody> </table> <p>Protection factors (at the level of the child, the family and the wider community)</p> <p>1.....</p> <p>2.</p> <p>3.....</p>		Low	Medium	High	1.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Low	Medium	High													
1.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>													
2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>													
3.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>													
<p>Immediate action needed? <input type="checkbox"/> yes <input type="checkbox"/> No If yes, what kind of action</p>																
<p>Short, Middle or long term action needed? <input type="checkbox"/> yes <input type="checkbox"/> No If yes develop an action plan</p>																
<p>CHILD PROTECTION WORKER (Name, profession and signature)</p>																



APPENDIX 6: RISK ASSESSMENT GUIDE⁴⁰

Type of harm	LEVEL 1 CHILD SIGNIFICANTLY HARMED; URGENT RESPONSE AND FREQUENT FOLLOW UP REQUIRED (Recommended response within 24 hours and bi-weekly follow up)	LEVEL 2 CHILD HARMED; RESPONSE AND FOLLOW UP REQUIRED (Recommended response within 3 days and weekly follow up)	LEVEL 3 CHILD AT RISK OF HARM; MONITORING REQUIRED (Recommended response within 7 days and fortnightly to monthly follow up)	LEVEL 4 CHILD NO LONGER AT RISK; NO FURTHER ACTION REQUIRED; CASE CLOSURE (Consider external monitoring with new referral to cpu if needed)
Violence (physical abuse)	Serious injury Infant or toddler injured in DV Child attempted to suicide incident	Excessive corporal punishment Threats to injure Dangerous and reckless behaviour Child is self harming	Threats to injure Non injurious, occasional corporal punishment	No violence present (factors causing the harm have been addressed or removed) Person causing harm no longer has contact with the child
Abuse (sexual and emotional abuse)	Any sexual contact between a child and an adult (where person causing harm has access to the child) Child is being persistently belittled, isolated, or humiliated by a significant carer	Child is promised to be married The child has been sexually violated in the past and not received any support Significant carers approach to the child is harmful (occasional belittling, isolation or humiliation)	Child is treated differently than other siblings and parent is negative towards the child	The child and family have received support and there are no sexual harm factors present Factors causing the emotional harm have been addressed (parent received support) Person causing harm no longer has contact with the child

40. Risk Assessment Guide, IRC Iraq, 2013

<p>Neglect</p>	<p>Serious injury or illness due to neglect (malnutrition with no apparent causal factors)</p>	<p>Lack of supervision Inadequate basic care Failure to protect The child is often left to look after themselves, or is undertaking tasks beyond his/her developmental capacity</p>	<p>Caregivers are emotionally distant</p>	<p>The child's basic needs are being met by the carer</p>
<p>Exploitation</p>	<p>Child involved in WFCL</p>	<p>Child underage forced to work</p>	<p>Parents are threatening to send the child to work</p>	<p>The child is no longer working, supports</p>
<p>Psychosocial distress (parent not coping, or not protective and/or no services involved)</p>	<p>The child has attempted suicide The child is engaging in very risky behaviours Child has stopped communicating/ The child's sense of reality is affected speaking The child has intense violent behaviours</p>	<p>The child's social skills, ability to self-care and retain school attendance is significantly impaired The child is using drugs and/or alcohol The child becomes frequently absent minded The child has distressing flashbacks The child is bed-wetting The child is often crying and/or sad The child has unexpected and intense fears, phobias and anxiety The child has sleeping and concentration problems The child is suddenly behaving much younger than his/her age The child is self harming</p>	<p>The child is sad and withdrawn The child is displaying anger</p>	<p>The child's psychosocial well-being is restored; the child is engaged in a range of activities and is not displaying behaviours of concern</p>



APPENDICES FOR REFERENCE:

Highly vulnerable children				
UASC	Unaccompanied child under 5 Separated child under 5 with unknown family UASC with level 2 harm factors	Unaccompanied child under 12 Separated child under 12 with unknown family Child headed household UASC (female) with unknown family	UASC who have had BIA and BID completed, who have carers, and their needs are being met	The child is being adequately cared for and the situation has been monitored for several weeks with no issues arising
Child previously associated with armed forces and armed groups	Child at risk of being recruited into armed forces and armed groups again Pregnant teenage girls Child parent	Unaccompanied child with difficulties reintegrating the community Previously associated with armed groups and armed forced and no support of services provided	Previously associated with armed groups and armed forced but accessing support and in a safe family environment	The child is being adequately cared for and no harm or vulnerability factors are present
Adolescent pregnancy/child parent	Unaccompanied adolescent pregnancy/child parent Adolescent pregnancy/child parent with level 2 harm factors	Adolescent pregnancy/child parent with psychosocial distress and difficulties with community and family reactions or low levels of support	Adolescent pregnancy/child parent with family support	Adolescent pregnancy/child parent with significant family support and networks
Child disabled or chronically ill	Child under 5 with level 2 harm factors	Child and family are not accessing the support that they need	Child disabled or chronically ill with challenging behaviours	Child disabled or chronically ill but has significant family support and the child and family are accessing all the supports that they need

<p>Domestic violence present in the home</p>	<p>Child under 5 with level 2 harm factors</p> <p>Child under 5</p> <p>Child is witnessing domestic violence and there are level 2 harm factors</p> <p>Significant injuries to the parent suffering the violence</p>	<p>Child and family are not accessing the support that they need</p> <p>Child is displaying emotional distress and difficulties learning and socialising</p>	<p>There has been sporadic disputes and violence, but the child is over 15 and has support networks</p>	<p>No violence present (factors causing the harm have been addressed or removed)</p> <p>Person causing harm no longer has contact with the child</p>
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APPENDIX 7: SAMPLE OF CASE PLANNING FORM⁴¹

Reference Code:				
Date Case Plan Agreed (DD/MM/YY):				
Date of Case Plan Review (DD/MM/YY):				
Needed Action	Issue Action Responds To	Responsibility	Due Date DD/MM/YY	Comments on Progress Made (dated)
Persons Involved in Making the Plan:				
Details of anyone who disagrees with parts of the plan and why:				
Reviewed and Approved by:				

41. Adapted from Standard Operating Procedures for Child Protection Case Management in Dadaab (2011) C. Jones for Save the Children (unpublished), Community based social work with children and families: Manual on Prevention and Reintegration (2005), Save the Children Bulgaria and Case Management Handbook for Child Protection Workers (2012) Terre des Hommes (unpublished).

■ APPENDIX 8: SAMPLE OF FOLLOW UP FORM⁴²

Reference Code:	Caseworker Code:	Date of Follow-Up (DD/MM/YY):		
Planning the Follow-Up				
Type of Follow-Up	Scheduled		Unplanned	
Location of Follow-Up	Child's Home	Office	Other:	
Purpose / Aim of Follow-Up	Assessment	Monitoring	Support	Other
Details of Follow-Up (including any comments on the above especially purpose / aims):				
Details of the Follow-Up				
Names and agencies of all agency attendees and other non-family participants:				
Names of all family participants (including children):				
Key discussion points:				
Outcome of the meeting (including additional points noted / progress made / actions planned – to be updated in case file):				
Dynamics of the meeting:				
Did you have the opportunity to speak with the child whose case it is individually? If yes, what was the outcome of the discussion?				
Next Follow-Up			Date (DD/MM/YY):	
Type, location, purpose / aim:				

42. Adapted from: Case Management Handbook for Child Protection Workers (2012) Terre des Hommes (unpublished) and Training Manual Inter-agency Child Protection Information Management System (2012) A. Brusanti and L. Haines for UNICEF, Save the Children and the International Rescue Committee, available from: <http://www.childprotectionims.org/>



APPENDIX 9: SAMPLE OF CASE CONFERENCE REPORT⁴³

Date (DD/MM/YY) ___/___/___ Name of Chair: _____ NB: Planned actions to be updated into individual case plans by caseworkers					
CASE CONFERENCE MINUTES					
Reference CodeDate: (DD/MM/YYYY)	Caseworker Code	Date Case Opened Location:	Protection Needs and Other Risks	Progress / Completed Actions Chair of the meeting:	Planned Actions and Resources Needed

1. ATTANDANCE LIST						
Name:	Position:	Contact information:				
2. CASE INFORMATION						
Case number:	Primary vulnerability:	Actions taken up to date:	Assessment of current situation:	Recommended actions to be taken:	Timeline for actions:	Responsible person:

49. Adapted from Standard Operating Procedures for Child Protection Case Management in Dadaab (2011) C. Jones for Save the Children (unpublished).



APPENDIX 10: CASE CLOSURE FORM⁴⁴

1. Reason for case closure – choose one option	Yes	No
The child has moved out of Tdh operational area		
The child has died		
The child and / or family no longer willing to participate		
All objectives agreed in the care plan have been met		
Not all objectives agreed in the care plan have been met, however significant progress has been made		
Comments:		
2. External verification – answer all	Yes	No
Child has completed a well-being checklist and the checklist indicates that he / she has recovered		
The child's teacher / CFS animator / neighbours confirm that the child has recovered		
Comments:		
3. Communication with the child and his / her family – answer all	Yes	No
The child and his / her family know who to contact in case of further problems and has the relevant contact details		
The child and his / her family have been informed that the case will be closed		
Comments:		
4. Tdh accountability mechanisms – answer all	Yes	No
Any on-going concerns have been discussed with the Social Work Supervisor and / or Manager		
The Social Work Supervisor and / or Manager has reviewed the case file and signed off on case closure		
Advocacy issues have been noted and addressed to the relevant actors		
Comments:		
Approved by – SIGNATURE	DATE	

44. Form developed from Terre des Hommes' Pillango database.

■ APPENDIX 11: CASE TRANSFER FORM⁴⁵

Reasons for Case Transfer		Reference Code:	
Child moving to new location <input type="checkbox"/>	Need for specialised services mean another agency is better placed to manage the case <input type="checkbox"/>	Organisational reasons <input type="checkbox"/>	Other <input type="checkbox"/>
Give reasons for the above:			
If Child / Family Moving Address:			
Contacts:			
Agency Details			
Agency receiving the case:		Agency transferring case:	
Contact person at agency:		Contact person at agency:	
Agency Address and Contacts:		Agency Address and Contacts:	
Date of transfer (DD/MM/YY):			
Details of Arrangements Made to Support Successful Transfer of Case			
E.g. Meetings between agency caseworkers and key points emphasised during them; introduction meeting with caseworkers, child and family; final follow-up visit from transferring agency etc.			
Case File Contents Transferred (List documents and whether copy or original – continue overleaf if needed).	<ol style="list-style-type: none"> 1. 2. 3. 4. 5. 6. 		
Ensure that Case Closure Form is completed on the final follow-up meeting with child and family.			
Form Completed By			
Caseworker Code:	Signature:	Date (DD/MM/YY):	
Authorized By			
Supervisor Code:	Signature:	Date (DD/MM/YY):	

45. Adapted from: Training Manual Inter-agency Child Protection Information Management System (2012) A. Brusanti and L. Haines for UNICEF, Save the Children, International Rescue Committee: <http://www.childprotectionims.org/>

■ APPENDIX 12: SAMPLE OF DATA PROTECTION PROTOCOL⁴⁶

TEMPLATE DATA PROTECTION PROTOCOLS

The following document reflects the best practices for protecting data and is to be used as guidance when developing data protection protocols for your programme. The information below should be reviewed and adapted to meet the specificities of the country and context you are working in.

It is important to remember that information on children belongs to the children. Those who keep the information do so on their behalf and should use it only in their best interest, and with their informed consent. The following data protection protocols are based on the concept of confidentiality, which is a central component of the principles of best interest and participation for children⁴⁷.

Confidentiality means ensuring that information disclosed to you by a child is not used without his or her consent or against his or her wishes and is not shared with others without his or her permission, except in exceptional circumstances (i.e. where serious safety concerns are identified (see point 8) or where service providers are required by law to report abuse (see point 9)). Information can be stored or transmitted verbally, on paper or by electronic data.

Confidentiality is in the best interest of a child because it prevents the misuse of information about them for purposes beyond their control, including for purposes leading to their exploitation, stigmatization and abuse – either intentionally or unintentionally. It also helps to ensure that their views and opinions are heard and respected at all times.

KEY DEFINITIONS:

Confidentiality: the principle that requires service providers to protect information gathered about clients and ensure it is accessible only with a client's explicit permission

Informed consent: the voluntary agreement of an individual who has the capacity to understand, and who exercises free choice to receive services (for children and adults aged 15+⁴⁸), requires caseworkers to share information on services, and the potential risks of such information sharing

Informed assent: the expressed willingness to participate in services, for children under below the age of 15⁴⁹ years, requires the same sharing of information (in a child-friendly format) on services and potential risks

Mandatory reporting: the term used to describe legal or statutory systems that require service providers to report certain categories of crimes or abuse (e.g. sexual violence, child abuse, etc.); best interests of the child should be considered when agencies are considering whether or not to comply with such policies

46. Adapted from the IA CP IMS

47. These principles are outlined in the United Nations Convention on the Rights of the Child, and the Organization of African Unity African Charter on the Rights and Welfare of the Child.

48. The age can be adapted based on the maturity of the child.

49. Ibid.

Need-to-know: the limiting of information that is considered sensitive, and sharing it only with those individuals for whom the information will enable to protect the child

GENERAL DATA PROTECTION

1. It is important to have a clear understanding of the context you are working in. Before starting to use the database, an assessment should be carried out that reviews all applicable domestic data protection laws and the possible implications they might have for staff and the organizations involved. This process should also take into consideration the level of sensitivity of the data that will be collected related to security risks specific to the context. In cases where data will need to be shared or transferred across borders, agencies should consider potential constraints to protecting data (eg. security officials at borders who may request to access data).
2. All staff involved in the work should be aware of the data protection protocols and the security implications of sensitive data.
3. All agencies holding information on children should have a written data protection policy, based on the principle of confidentiality, which should ideally be framed within the agencies' broader child protection policy. An obligation to uphold this policy should be written in to staff contracts.
4. All children on whom information is gathered should be allocated a code based upon an agreed upon standard coding format. This format may indicate areas of identification or areas of origin but should guarantee anonymity of the child. The code should be used to refer to the child's case either verbally, on paper or electronically (including in word documents, emails, skype conversations, etc.) in place of any identifiable information such as name or date of birth. All files should be stored according to the allocated code.
5. Access to information on children should be limited only to those who need to know it and to whomever the children agree to know it.
6. Those gathering information must obtain informed consent from the child (and/ or their parent/ caregiver), preferably in written form. When children are too young (usually under 15 years) to consent, their informed assent should be sought (i.e. willingness to participate in services) while a parent or caregiver gives consent. The informed assent/ consent process must include explaining to the child (and their parent/ caregiver, where appropriate) exactly why they are gathering information, how it will be used and by whom. Information should be shared in language and formats appropriate to the child's age and capacity to understand, and the child (and parent/ caregiver) should be given opportunities to ask questions. In situations where mandatory reporting laws exist and are functioning, service providers must explain these limits on confidentiality when obtaining consent. Even with very young children (i.e. under 5 years old), efforts should be made to share and explain information in an appropriate format.
7. Children should be given the opportunity to highlight any information that they do not want disclosed to any particular person. For example, they may not want their family to be told personal details about them that they would rather communicate face-to-face or not at all.

8. In exceptional circumstances, information disclosed by children can be shared against their wishes if it is considered – after careful evaluation - in their best interest to do so, but the reasons for doing so must be clearly explained to them. There is no hard or fast rule for disclosing information shared by a child, but generally, information should be shared when the child or another person is at risk of being harmed. Because this is subjective, each case should be considered individually, and decisions to disclose information should be taken at the highest level of the agency or agencies involved.
9. In some settings, **mandatory reporting laws** exist that require service providers to report cases of actual or suspected abuse to a central agency, limiting confidentiality between agencies and their clients. Where these laws exist and are functioning, they should be explained to the child (and/ or caregiver) during the informed consent process. In some cases, mandatory-reporting systems may be seriously flawed (e.g. because of lack of clear procedures and guidelines, lack of capacity to respond, etc.) and can further jeopardize children and families safety, particularly in emergency settings. Service providers should then consider the child's safety and best interests along with the potential legal implications of not reporting to determine the appropriate next steps. **Decisions regarding compliance with mandatory reporting laws should be taken at the highest level of the agency involved, for the protection of the workers.**
10. After gathering information, it should be passed only to a person designated to receive it, for clearly defined purposes, such as a line manager or partner agency. Information sharing lines must be clearly mapped out and understood by all staff. Passing information between different agencies requires that all agencies concerned comply with the standard data protection protocols.
11. Children have the right to access and review information held about them. Agencies holding information should therefore make provisions for them to be able to access their information as and when they need to do so.
12. Staff working directly with children must receive regular debriefs for their own well-being. During debriefs, information disclosed by staff about children should be discussed anonymously. If there is a need to break such anonymity, this should be done with the person designated to receive the information and in conformity with the best interest of those concerned.
13. It is important for managers to make sure that the data protection protocols are being followed through regular monitoring and mentoring of staff and that they are updated when needed (e.g. if changes in the context occur).

Paper file security

14. Each case should be stored in its own individual file, clearly labelled with the individual case code on the outside of the file. **It is imperative** that the child's name does not appear on the outside of the file.
15. Paper files should be kept in a secure place, accessible only to the person responsible for the information. This usually means that they are stored in a lockable filing cabinet, and the keys kept with the person responsible for the information. No one else should be given independent access without permission.

16. Paper files should be transferred by hand between people responsible for the information. During transfer, the files should be stored in a sealed box or sealed envelope. In exceptional circumstances the Child Protection Manager may need to identify a non-Child Protection staff member to be designated for this task. In this circumstance, the staff member must be briefed on the Data Protection Protocols and sign these.
17. Original documents (such as birth certificates) should be scanned and then returned to the child. Original documents should not be stored in paper files so that destruction of paper files can be done without any hesitation in the event of an emergency evacuation/relocation.
18. Paper files and/or filing cabinets should be marked with a color-coding system according to sensitivity of data they contain and therefore the order of priority in which they should be removed/destroyed in the event of an emergency evacuation/relocation.
19. Rooms containing paper or electronic information should be kept securely locked when the person responsible for the information leaves the room.

Electronic data security

20. Computers should be fitted with up-to-date anti-virus software so as to avoid corruption and loss of information.
21. All electronic information on children should be password protected, and the password changed on a regular basis. Information should be transferred by encrypted or password protected files whether this is by internet or memory sticks. Memory sticks (USBs) should be passed by hand between people responsible for the information and be password protected, and the file erased immediately after transfer. Ensure that the file is also permanently erased from the recycle bin file of your computer.
22. At least two backups should be taken on a weekly basis; one to be stored in the location of the database, and second to be sent for secure storage in a pre-defined centralized location. The reason for having an off-site back-up is so that the data can be retrieved if the main database becomes damaged (due to flooding, for example). It also means that the main database can be destroyed in an emergency evacuation/relocation without this meaning the loss of all electronic data. Typically, the on-site back up is an external hard drive which is kept locked in a filing cabinet, and the off-site back up is done through emailing the database to the designated receiver as an encrypted, password-protected zip file.

Emergency evacuation/relocation plan

23. In the event of an evacuation/relocation, management must ensure that the computer(s) where the database is setup, their back up systems and paper files are moved to a safe location. When moving database assets and paper files is not possible, management should ensure assets are destroyed and papers burnt. Information saved in back up systems will then become the only source of information on the children. It should be noted that in some circumstances, it may not be necessary to destroy files and therefore is more important to ensure they are properly secured and protected during the period of evacuation/relocation. This is a judgment call that will need to be made by management.

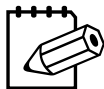


24. A clear evacuation/relocation plan should be developed that outlines a 'scheme of delegation' dictating who has responsibility for making decisions regarding removing or destroying data (for both paper and electronic data). This plan should be incorporated into the standard evacuation/relocation plan for the whole agency by security managers/senior staff.
25. The country director, security manager, logistic manager, IT manager, senior management team and child protection staff should know their individual responsibilities detailed in the evacuation/relocation plan and be aware of the sensitive nature of data being collected. Briefing on the evacuation plan should be part of the standard induction checklist for relevant staff.
26. Evacuation/relocation drills should be carried out to ensure that each individual knows their responsibilities and is able to act quickly in an emergency evacuation/relocation. In the event of a deteriorating security situation, evacuation/relocation plans should be reviewed—and if necessary, re-evaluated—by senior management and security personnel.

Lead agencies

27. Lead agencies in an inter-agency network are responsible for overseeing that all other agencies have appropriate data protection protocols in place, including evacuation/relocation plans.
28. In case of an emergency evacuation/relocation, lead agencies should coordinate with other agencies in the network to ensure that all agencies are able to evacuate without compromising data security and confidentiality.
29. Lead agencies should contact the IA CP IMS Steering Committee and/or the Project Coordinator as soon as possible to alert them to the evacuation/relocation and seek support as necessary.

5 CASE MANAGEMENT FOR CHILD SURVIVORS



TOOL: SAMPLE INFORMED CONSENT/ASSENT AND CLIENT RIGHTS STATEMENT

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



SAMPLE SCRIPT INFORMED CONSENT/ASSENT AND CLIENT RIGHTS STATEMENT

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

Hello [name of client].

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

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

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

50. Implementation Guidelines. Caring for Child Survivors of Sexual Abuse in Humanitarian Aid Setting. IRC. 2011



CARING FOR CHILD SURVIVORS OF SEXUAL ABUSE GUIDELINES



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

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

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

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

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

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

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

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

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

■ APPENDIX 14: SAMPLE OF GUIDANCE NOTE FOR INFORMED CONSENT⁵¹

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

They are:

- At the start of case management services (that is, before conducting the initial intake and assessment interview).
- As part of case management, children and caregivers also need to provide their permission for the caseworker to collect and store information about their case throughout the case management process.
- During case referrals, when caseworker share information with other service providers who can help the child and family meet their specific needs.

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

- the caseworker's role and responsibilities in case management;
- what case management includes (e.g. listening to problems, identifying needs, helping to meet needs), including the benefits and limitations of the service;
- what confidentiality means and how sometimes confidentiality cannot be kept and why, including conditions for which mandatory reporting is required.
- how the client information will be safely and securely stored (this includes any case forms and database being used)
- how the client information will be used (if used for data collection, information sharing, or other purposes).
- Caseworkers should always offer children and caregivers the opportunity to ask questions or share concerns during this discussion.

HOW TO OBTAIN PERMISSION FROM CHILDREN AND CAREGIVERS

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

51. Implementation Guidelines. Caring for Child Survivors of Sexual Abuse in Humanitarian Aid Setting. IRC. 2011

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

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

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

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

Young children (ages 0-5)

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

Very young children are not sufficiently capable of making decisions around care and treatment and as such for children this age range informed assent will not be sought. However, the service provider should still seek to explain to the child what is happening, in very basic and appropriate ways.

For Younger children (ages 6-11)

Typically, children in this age range are not legally able nor sufficiently mature enough to provide their informed consent for participating in services; however, they are able to provide their informed assent or 'willingness' to participate. Children in this age range should be asked their permission to proceed with services and actions which affect them directly. This permission can be provided orally by the child, and documented as so on the informed consent form. For children in this age range, written parental/caregiver informed consent is required, along with the child's informed assent. If it is not possible to obtain informed consent from a parent or caregiver, another trusted adult (identified by the child) who can be safely brought into care and treatment decisions should be approached to consent for the child.

Older children ages 12-14:

Children in this age range have evolving capacities and more advanced cognitive development, and therefore may be sufficiently mature enough to make decisions on and provide informed assent and/or consent for continuing with services. Standard practice should be that the caseworker seeks the child's written informed assent to participate in services, as well as the parent/caregiver's written informed consent. However, if it is deemed unsafe and/or not in the child's best interest to involve the caregiver, the caseworker should try to identify another trusted adult in the child's life to provide informed consent, along with the child's written assent. If this is not possible, a child's informed assent can have due weight if the case worker assess the child to be mature enough and the caseworker can proceed with care and treatment under the guidance and support of their supervisor.

Older Adolescents (ages 15-18)

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

If the adolescent (and caregiver) agree to proceed, the caseworker documents their informed consent using a client consent form or documenting on the case record that they have obtained verbal consent to proceed with case management services. Note: Caseworkers are required to follow informed consent/assent procedures and guidelines during the case action planning step when referrals for additional services takes places.

Special Situations

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

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

In situations where children and/or caregivers are hesitant to proceed, caseworkers should ask additional questions to determine the hesitation to receive services. Perhaps the child and/or caregiver are afraid of losing their confidentiality because of a mandatory reporting law. Here the caseworker can further discuss their right to participate in how to share information if it's necessary (e.g. in a mandatory reporting situation) and/or further discuss the risks to reporting. If serious risks are identified, then it may not be in the best

interest to report and the caseworker can further explain and discuss this with the client and then, with his or her supervisor. Caseworkers should take the time to discuss the child and caregiver’s fears and concerns with proceeding with case management and provide clear and accurate answers to help address specific fears and concerns.

SNAPSHOT OF INFORMED CONSENT/ASSENT GUIDELINES

Age group	Child	Caregiver	If no caregiver or not in child best interest	Means
0-5	-	Informed consent	Other trusted adult or case worker informed consent	Written consent
6-11	Informed assent	Informed consent	Other trusted adults or case worker informed consent	Oral assent Written consent
12-14	Informed assent	Informed consent	Other trusted adult or child’s informed assent and sufficient level of maturity can take due weight	Written assent Written consent
15-18	Informed consent	With child’s permission obtain informed consent	Child’s informed consent and sufficient level of maturity takes due weight	Written consent



APPENDICES FOR REFERENCE:

