Working Protocol:

Inter-Sectorial Collaboration in Child Protection Cases

DEFENCE for CHILDREN

Ministry of Foreign Affairs of the Netherlands

Working Protocol:
Inter-Sectorial Collaboration in Child Protection Cases

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Abbreviations

CMR	– Case Management Roundtable
CP	– Child Protection
CPSW	– Child Protection Social Worker
SW	– Social Worker
CSW	– Center of Social Work
CM	– Case Management
GBV	– Gender-based violence

Contents

Acknowledgment's

The organizations for children's rights, Defence for children - ECPAT the Netherlands and Terre des hommes Kosovo have, with financial support from the Dutch Ministry of Foreign Affairs, collaborated with the aim of assisting professionals in the field of child protection. The development of the ***Working Protocol: Inter-sectorial collaboration in child protection*** will highly contribute to the efficacy of all agencies working in the field of child protection by explaining the responsibilities for respective agencies and actions which should be taken in order to act in the best interest of the child. Thus, the Working Protocol targets the current professionals of different agencies which its mandate relates to child protection but also build capacities in this field, so that the provided services will be qualitative and in line with applicable laws in Kosovo as well as with the International Convention on Child Rights.

The joint expertise and experience of the following local experts and Dutch experts have brought together the best practice of multi-agency working by taking into account the applicable laws of Kosovo: **Bajram Kelmendi** – Head of Social Service Division; **Vebi Mujku** – Director of the Center for Social Work - Pristina; **Shyqri Mehmeti** – Director of the Center for Social Work – Ferizaj; **Gani Lluka** – Executive Director of ASTRA; **Lulzim Dragidella** – Lecturer and Head of Department of Social Work, Prishtina University; **Alketa Lasku** – Deputy Country Representative, Tdh Kosovo; **Naim Bilalli** – Case Management Roundtable Coordinator, Tdh Kosovo; **Visar Kryeziu** – Child Protection Unit Coordinator, Tdh Kosovo.

Special thanks go to the Dutch Experts **Myra ter Meulen, Ieta Polman and José Hermans** and to the project coordinator **Mrs. Ytje Hokwerda – Defence for Children – ECPAT the Netherlands.** In addition a special thanks to the International Expert on Child Protection Mrs. Stephanie Delaney for the technical revision.

The Working Protocol will be an added value not just for professionals of Kosovo but also for professionals of other countries by having the chance to access online the web-platform www.childhub.org, where this document is available in English, Serbian and Albanian Language.

Introduction

Good practice and research shows that the best ways to protect children is when agencies work together by sharing information, taking joint decisions regarding the best interest of the child and collaborating in actions to support the child and their family. This is because children's lives are complex, and one agency or organisation working in isolation cannot hope to meet all children's needs.
There are many different ways of describing this process of working together:

- *Inter-sectorial working or collaboration*
- *Multi-disciplinary / multi-disciplinary team working*
- *Multi-sectorial / multi-sectorial team working*

Multidisciplinary work in CMR based on internal regulation that is compiled and approved by members of CMR focused in organization, coordination, cooperation, sharing of responsibilities and solutions, while protecting the best interests of children and it is conformed Law 02 / L-17 on Social and Family Services (see **Appendix 1**).

Purpose of the Protocol

This Protocol covers multi-disciplinary working under the Law as it currently stands, and in line with general current practice in Kosovo. As reforms of the law take place, this protocol may need to be revised. In its present form it should be considered a working document, subject to review with the agreement of all agencies involved in child protection work.

The Protocol has been developed in order to standardise, unify and coordinate the work of all agencies who are, or should be, working together to protect children. It sets out the expectations and responsibilities of agencies, and also identifies specific actions are required, for example when a Case Management Roundtable (CMR) is required.

In addition this document includes key information to help representatives from different agencies to understand and work within a multi-disciplinary approach. This is essential for those who are nominated to participate in formal structures established such as the CMRs.

Since this protocol is about multiagency working and not case management, of which multi-disciplinary working is only a part, it does not cover all the processes involved in case management, or the detail of how to apply each stage. However it does examine the elements of case management which are relevant to multi-disciplinary working and which workers need to know.

Terminology Used in the Protocol

For the purposes of clarity and ease of reading in this document the following terms are used:

'Abuse' – Used generically and in its widest sense to describe harm, and potential harm, which children may be at risk of or are actually suffering. A more detailed definition of child abuse is considered in Section X.

'Agency' / 'agencies' – Any and all organisations or government ministries and departments. When necessary to distinguish a particular agency, for example if discussing responsibilities, that particular agency name is used.

'Inter-sectorial', 'multi-agency' and 'multi-disciplinary' – All used interchangeably to mean the same thing; agencies working together to protect children.

'Worker' / 'workers' – Any / all members of staff or volunteers working for an agency. When necessary specific roles are named; otherwise it should be assumed that the statement applies to all workers.

Format of the Protocol

The Protocol is divided into two main sections.

Section 1 – Considers multi-disciplinary working generally in Kosovo, and explores some key issues relating to child protection which are necessary for those involved in multidisciplinary working to protect children.

Section 2 – Explores one specific mechanism related to multi agency working in Kosovo, the Case Management Roundtable, also known as a Task Force.

Supporting documentation and further resources are included in the **Appendices**. A comprehensive **Glossary** can be found at the end of the Protocol.

Principles Underpinning the Protocol

A number of principles form the basis of good practice with children and families, and underpin the Protocol:

Best Interests of the Child

The 'best interests' of the child must be a primary consideration for all decisions and actions taken and for the way in which organisations and agencies interact with children and their families. Ensuring the best interests of the child means ensuring that children's needs are met and their well-being is prioritised. This should guide all decisions made. Central to decisions

about the best interests of children is the commitment to upholding and realising children's rights, as enshrined in the *United Nations Convention on the Rights of the Child, 1989.*

Do No Harm / Least Harm

Actions and interventions designed to support the child (and their family) should not expose them to further harm. Care must be taken to ensure that no harm comes to children or their families as a result of staff conduct, decisions made, or actions taken. 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. Unless care is taken, this may expose a child and his/her family to further harm such as revenge acts or violence.

While the goal should always be to do no harm, often in child protection there is no one ''ideal'' solution possible, but rather a series of more or less acceptable choices which may have a negative impact on the child. For example the decision to remove a child from home because it is not safe for them to remain will have negative consequences on the child, although it may still be in their best interests because *on balance* staying at home may be more dangerous.

Non-discrimination

Children and their families should not be 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).

Informed Consent

In all circumstances, consent should be sought from children and their families or caregivers prior to providing services. To ensure informed consent, it must be explained to children and their families, in ways that they can understand, the services and options available, potential risks and benefits to receiving services, information that will be collected and how it will be used, and confidentiality and its limits. Efforts should be taken to ensure that even very young children are consulted or at least should have a clear explanation of what will happen.

In child protection cases, where a child is at high risk if the family or child is not prepared to consent to intervention, this may still be necessary even if against the wishes of the child and their family to ensure the child is protected. This is in line with international guidance on working with children who are at risk.

Meaningful Participation of Children & Families

Children have a right to participate in decisions which affect their lives and for their wishes and feelings to be taken into account. Children and families should always been consulted and involved in decision making.

Building Upon Strengths and Existing Resources

Children and families should not be seen as passive victims but as people with strengths and capacities. These should be capitalised on in order to ensure that people are empowered to effect change in their own lives and as a basis for intervention.

Providing Services in Culturally Sensitive Ways

Support should be provided in culturally sensitive ways – for example by considering how communities and families normally support each other and deal with difficulties. There are many different ways of caring for children which are equally valid, however culture should never be used as an excuse for abuse.

Decisions Based on Child Development and Evidence

Decisions made should be based on child development and evidence, not on the personal beliefs and bias of workers.

Collaboration and Co-operation Between Agencies

Better outcomes for children result for organisations and agencies working together. Even where only one agency is working with a case, decisions regarding child protection concerns should never be made by an individual worker, but should be made as a group / in consultation with a supervisor.

Mandatory Reporting

It should be clear to all workers that all concerns relating to the protection of children must be reported within their organisation and that individual workers cannot make decisions to keep information private when it relates to child protection. Even if a suspicion or concern is vague it should always be reported. This should be in accordance with the specific agency guidelines which all agencies should have in place if working with children.

Organisations Should be Safe for Children

Organisations and agencies working with children should safeguard children. This means that their own organisations must ensure that the way they operate do not expose children to risk or harm. For example workers should be properly trained and supported so that they can carry out their tasks appropriately.

Section 1

Multi-agency Working and Child Protection

Dimensions of Multi-disciplinary Working

General Responsibilities of all Agencies

In general all agencies should to work together to protect children. This includes:

- Identifying children who may be at risk or are at risk and who need support.
- Referring cases of concern to the Center for Social Work.
- Sharing information in a timely and comprehensive way so to facilitate the assessment of children's situation (see also section on consent and information sharing).
- Attending coordination meetings as required. For example in **medium and high risk cases** participating in the Case Management Roundtables (CMRs).
- Supporting any plans develop to support the child and their family, such as by providing services as set out in the plan.
- Providing updates on progress.

While undoubtedly good personal relationships positively influence and ease multi-disciplinary working**, it is never acceptable for personal or agency conflicts or rivalries to negatively impact multi-agency working** as this can leave children unsupported or unprotected. Where such unhelpful dynamics exist within multi-agency teams, workers have a responsibility to report this to senior managers so that appropriate solutions can be identified.

Connections Between Case Management & Multi-disciplinary Working

Case management can be defined as:

> *"The process of ensuring that an identified child has his or her needs for care, protection and support met. This is usually the responsibility of an allocated social worker who meets with the child, the family, any other caregivers, and professionals involved with the child in order to assess, plan, deliver or refer the child and/or family for services, and monitor and review progress."*[1]

To facilitate this, a case management system or procedure is normally developed. This is a set of defined steps or processes which are followed in all cases. This includes details of who should be involved, and when, and timescales for each stage. Such a system helps to ensure consistency in approach which is necessary so that all cases are treated equally and are dealt with in an appropriate way without any undue delay.

One person, normally a social worker, is appointed as the **Case Manager** and it is their responsibility to ensure that the case management process is followed. This includes coordinating the actions of the various agencies involved.

Multi-disciplinary working is normally a feature of case management procedures, with a requirement that agencies work together.

Steps in the Case Management Process and Multidisciplinary Working

Case management is:

- Focused on the needs of an individual child and their family, ensuring that concerns are addressed systematically
- Provided in accordance with the established case management process, with each case through a series of steps
- Incorporates children's meaningful participation and family empowerment
- Involves the coordination of services and supports within an interlinked or referral system where necessary in order to holistically meet needs and maximise resources
- Ensures accountability through clear lines of responsibility at every stage of the process.

The key stages in the case management process which relate to multi-disciplinary working can be illustrated in figure 1:

1 Better Care Network Toolkit Glossary, Better Care Network, 2014

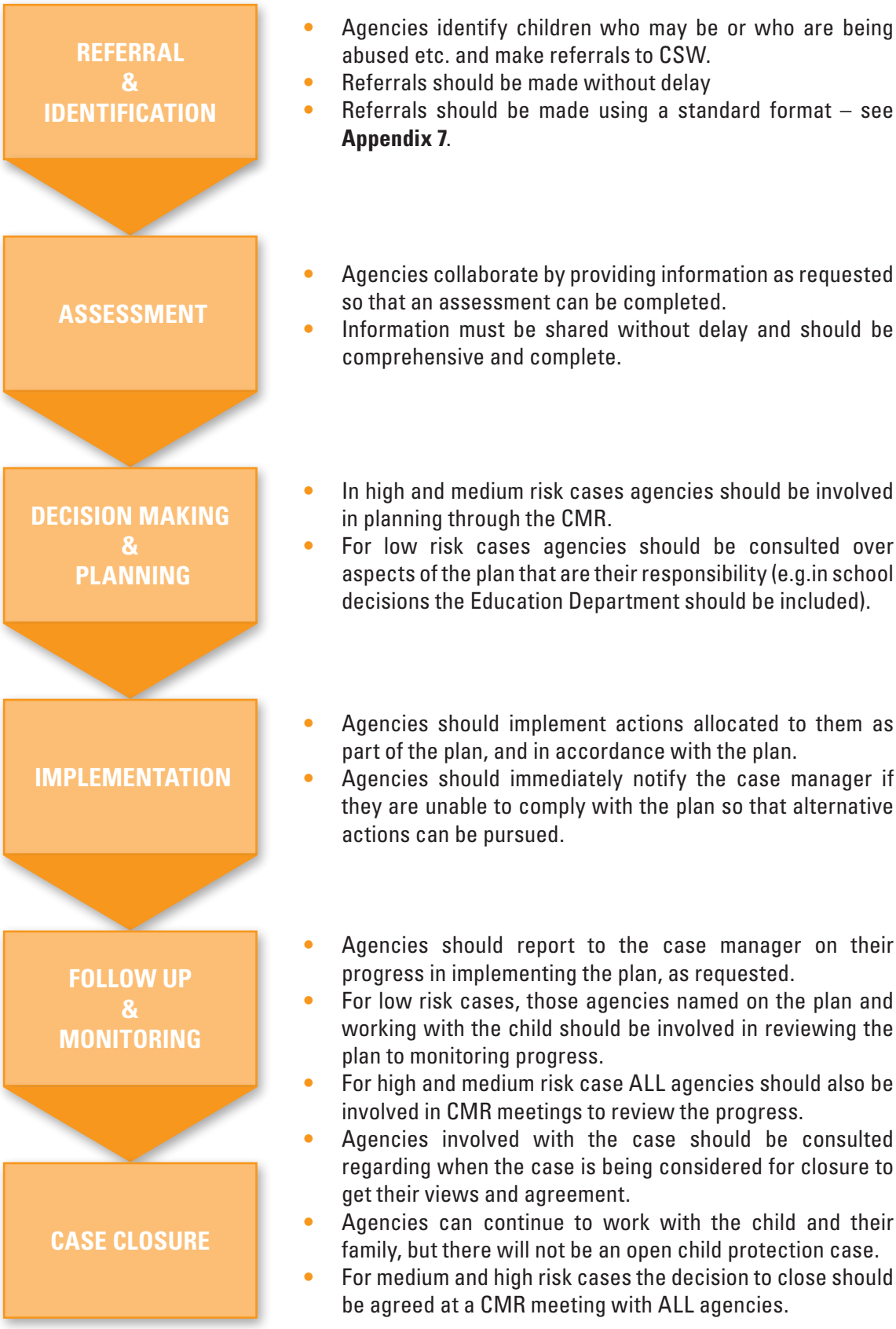


Figure 1: Multi-disciplinary working and key stages of case management

Understanding Risk and Protection

In order to function effectively, a shared understanding of child protection and child abuse, together with an appreciation of risk levels, is essential. Different agencies define such ideas and models in a variety of ways, usually reflecting their organisational focus, values and approaches and so it is important in multi-disciplinary working to make sure that there is common agreement.

Child Protection relates specifically to the protection of children from abuse, not as is sometimes understood the protection of children's rights generally. For example, health and education are not normally considered as child protection concerns although they still need to be addressed in order to ensure that children's rights are upheld and the needs are met.

Definition from Law - Protection of children – means the activities undertaken to protect children suffering, or are likely to suffer from a serious risk and any other attempt to ensure that children live in a family or some other safe environment, where life and health are protected ,and their rights are respected, where education and development are provided, by protecting them against any form of violence, utilisation, corporal punishment, maltreatment, exploitation, neglect, abuse and utilisation in every context, including, but not limited to abduction, sexual abuse, trafficking, child labour and harmful traditional practices, such as mutilation of genital organs, wedding of children and abuse.

Defining Child Abuse

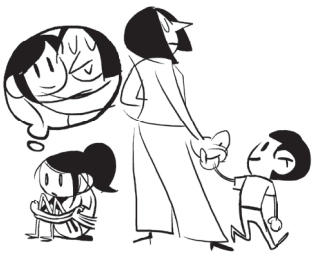
Categories of Abuse

Four main categories of abuse are recognised:

Physical Abuse: This may involve hitting, shaking, throwing, burning or scalding, drowning, suffocating, or otherwise causing physical harm to a child. Physical harm may also be caused when a parent or carer feigns the symptoms of, or deliberately causes, ill health to a child who they are looking after.

Sexual Abuse: Involves forcing or enticing a child to take part in sexual activities, whether or not the child is aware of what is happening or gives consent. The activities may involve physical contact, including penetrative (e.g., rape) or non-penetrative acts. They may also include non-contact activities, such as involving children in looking at, or in the production of, pornographic materials or watching sexual activities, or encouraging children to behave in sexually inappropriate ways.

Emotional Abuse: This is the persistent emotional ill-treatment of a child such as to cause severe and long lasting effects on the child's emotional development. It may involve conveying to children that they are worthless and unloved, inadequate, or valued only so far as they meet the needs of another person. It can also involve age or developmentally inappropriate expectations



being imposed in children, or causing children frequently to feel frightened or in danger. Some level of emotional abuse is involved in all types of ill-treatment of a child, though it may occur alone.

Neglect: This is the persistent failure to meet the child's basic physical and/ or psychological needs, where the parent / carer has the capacity to do so, likely to result in the serious impairment of the child's physical or cognitive development. Neglect does not include situations of poverty, where a parent/caregiver cannot afford to provide for their child but is trying to do so.

Other types of abuse commonly recognised, such as commercial sexual exploitation, child labour, child marriage, trafficking etc., are complex manifestations of the combination of the above four categories.

Discrimination is also often cited as a form of abuse. In fact it is a vulnerability factor, as it is the effect of discrimination that leads to abuse

Abuse can be perpetrated by adults, but the abuser can also be a child (typically older or more powerful). In such cases it is often referred to as **bullying.**

Further information can be found in Appendix 2, Manifestations of abuse and in the Glossary.

Indicators of Possible Abuse

Children frequently do not speak out directly about abuse that they might be experiencing – especially those who are very young or have communication difficulties, or are not used to being listened too (and believed).

All adults need to be vigilant to signs and symptoms that might indicate that abuse or has been a feature of the child's life. At this stage, it is not important for staff from agencies to have ''evidence'' that something has happened, but instead to be alert and to raise concerns and make a referral so the situation can be carefully assessed.

See Appendix 3 for Signs and symptoms of abuse.

Risk & Vulnerability

When considering abuse, it is also important to consider the **level of risk**. This will be different depending upon the nature of the risk, the unique circumstances for the child which may make a child more or less vulnerable (such as age and development), and the presence of factors which may be able to protect the child. Risk can change over time (ie.in the short, medium and long term).

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.

Factors influencing level of risk		
Nature of Risk	**Vulnerabilities**	**Protective Influences**
Parental substance and alcohol abuse	Age	Emotional Maturity
Domestic abuse	Born Premature	Mature moral development
Known or suspected sex offenders, drug dealers, traffickers	Learning difficulties, disabilities	Evidenced personal safety skills
Known or suspected neglect	Physical disabilities	Strong self esteem
Mental illness	Isolation	Evidenced resilience and strong attachment
Economic or social misadventure	Communication difficulties	Protective adults and or identified peers
Hostility and or lack of cooperation from parent	Running away from home	Demonstrable capacity by parents and the sustained acceptance of the need to change to protect the child
History of concerns or little or no change of situation	Conduct disorders	Strong social networks
Family not prioritising child's needs	Mental health problems	
	Substance abuse	
	Self-harm	

The level of intervention and support required will depending on the unique combination of risk, vulnerability and protective influences, as shown in figure 2:

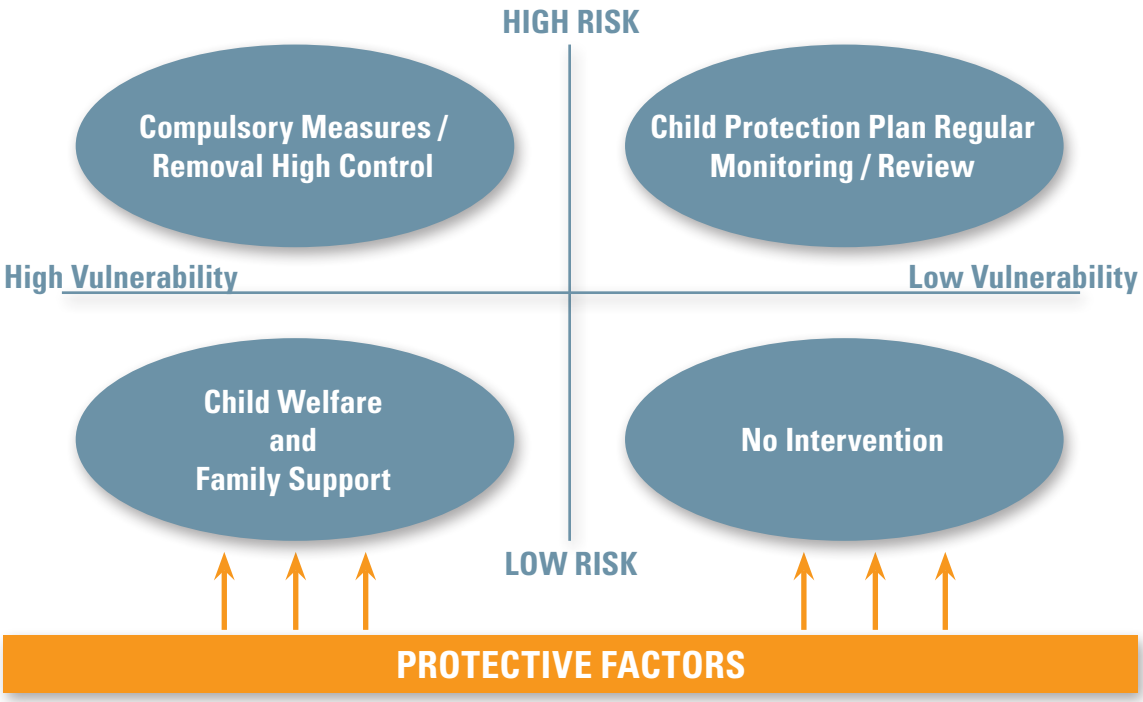


Figure 2: Dimensions of intervention

Risk Levels

As mentioned in the previous section, the individual level of risk that a child is exposed to is determined by a combination of factors. These specifics are important to know and understand in order to, if necessary, intervene in the most appropriate and helpful way. However, for practical purposes, in order to be able to systematically manage cases and work together as a multi-agency team, it is useful to be able to broadly identify and categorise the level of risk.

- **Child at 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.**
- **Child at Medium Risk – A child is likely to suffer some degree of harm if he or she remains in the home 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.**
- **Child at High Risk – A child is likely to be seriously harmed or injured, subjected to immediate and ongoing sexual abuse, or be permanently disabled, trafficked or die if left in his/her present circumstances without protective intervention.**

Risk Analysis Framework

The following table is provided to give guidance to assessing the level of risk. **The overall level of risk should be the highest indicated from the table.**

Unaccompanied children are always considered as high risk cases until safe accommodation is secured for them and appropriate ongoing support is made available.

Once the child's situation has been thoroughly assessed, the different sources of risk must be identified, and addressed in the Care Plan.

Risk Analysis Framework			
Influencing Factors	**Low Risk**	**Medium Risk**	**High Risk**
Child age and protective capacity	Child is over 10; child does not need or only very minimally needs the care and support of an adult in order to protect himself (for example by being able to recognise and avoid situations of risk). No physical or developmental disabilities	Child age 5-9; child of any age who needs the assistance of an adult in order to protect or care for himself; introverted child; has light illness, cognitive/ physical disorder; has low or medium level developmental disability	Child is 5 or under; a child of any age who is entirely dependent on an adult for care and protection; a child with severe illness, cognitive disability or severe developmental disability. Child with severe behavioural problems.

Influencing Factors	Low Risk	Medium Risk	High Risk
Severity of Physical / Sexual Abuse	No harm or only light harm; no need to receive medical treatment; no detectible impact on the child; isolated incident	Mild physical injury or unexplained injuries; needs medical care or diagnoses; there is a history of severe discipline, non-contact sexual abuse	Needs to go to the hospital or stay in the hospital; family has a history of extreme discipline or there is a history of the sexual harassment; sexual contact between adult and child
Site of Injury	Knees, hands or buttocks	Torso	Head, face, or reproductive organs
Severity of any neglect	No detectible impact on the child; isolated incident	Concern that the caregiver cannot meet the child's most basic medical, nutrition or shelter needs even if they have the resources to do so; occasionally leaves child unsupervised	Caregiver is not willing to supply the child with medical/nutritional or shelter needs; child frequently left unsupervised (the extent of this depends on the age of the child)
History of previous abuse/neglect	No history of abuse or neglect	Previous reports of concern; protective services received in the past	Not known; previous reports of numerous or severe abuse; previous abuse with no protective services received
Opportunity abuser to contact the child	None - left the home / area and cannot contact the child	The abuser is still in the home / area but there is another adult present who can protect the child, and the child is not left alone	The abuser lives in the home / is present in the area, and can have access to the child easily; no ability to confirm whether or not other adults have the ability to protect the child

Influencing Factors	Low Risk	Medium Risk	High Risk
Caregivers physical, emotional capacity & parenting skills	No intellectual or physical impairment; reasonable expectations of the child; full ability to control his/her own; emotions/ behaviours; adequate parenting skills and recognises their responsibility	Some level of disability; some cognitive limitations; mental health problems, it takes planning and support care for child; quality of care inconsistent or very low; use of substances (e.g. drug and alcohol) occasionally interferes with parenting ability	Severe disability / cognitive impairment; unrealistic expectations or perceptions about the child's behaviour; low / no parenting skills; substance abuse which frequently compromises parenting ability
Availability of Other carers	Someone ready and able to take on the main caregiving role and who is able to offer support and stability	Someone in the family can take the role of main caregiver but they may not always be at home, or can only take part in meeting the most basic care requirements of the child or need additional support	No other suitable adult to care for child – either because lacks will / ability or may be a danger
Family / community support systems	Family members, neighbours or friends promise to provide support to the child; the family is involved in community activities	Family members, neighbours or friends can provide some support but this is limited	No family or community support; family and friends contribute to the problem; family lives in a remote area and are isolated; the family has no telephone or communication tools
Family living environment	The home is clean and there are no / few safety or health hazards	There is garbage and other unclean materials; no water / power; The family lives in temporary / unstable accommodation.	The family lives in a remote place or in unsuitable housing

Influencing Factors	Low Risk	Medium Risk	High Risk
Family stress/ other risk factors	Stable family, job, and income; close relationship with relatives	Pregnancy or a new-born baby; there is not enough income or food available; the family lacks skills for household management; there is conflict in relationships with relatives	Spouse has deceased / left or there is recent change in marital status; marital conflict; domestic violence
Family stress/ other risk factors	Stable family, job, and income; close relationship with relatives / community living in the vicinity	Pregnancy or a new-born baby; there is not enough income or food available; the family lacks skills for household management; there is conflict in relationships with relatives; child at risk of exploitation, including domestic labour, trafficking and child marriage.	Spouse has deceased / left or there is recent change in marital status; marital conflict; domestic violence; child exploited, including domestic labour, or trafficked or married.

Wellbeing Indicators

In child protection, a central consideration is the child's wellbeing, and the extent to which they have or may be affected.

Five well-being indicators have been identified as areas in which children and young people need to progress in order to do well and now and in the future:

1. **Safety -** Protected from abuse, neglect or harm at home, at school and in the community.

2. **Health -** Having the highest attainable standards of physical and mental health, access to suitable healthcare, and support in learning to make healthy and safe choices.

3. **Achievement -** Able to access education and be supported and guided in their learning and in the development of their skills, confidence and self-esteem at home, at school and in the community. This includes having opportunities to take part in activities such as play, recreation and sport which contribute to healthy growth and development, both at home and in the community.

4. **Nurture -** Having a safe and caring place to live, in a family setting with additional help if needed or, where this is not possible, in a suitable care setting such as a shelter or institution.

5. **Inclusion -** Help to overcome social, educational, physical and economic inequalities and being accepted as part of the community in which they live and learn. This includes having opinions and views and taken into account.

To determine the extent to which the wellbeing indicators are being met, which is an important consideration when developing care plans, it is import to consider the developmental needs of children, as children of different ages have very different needs. **Appendix 4** outlines **normal developmental milestones** (i.e. the development than can be expected to be attained as each age).

Involving Children & Parents

Apart from the important consideration that children have a right to participate in decisions which affect their lives (Article 12, UN Convention on the Rights of the Child), an open and transparent approach that actively involves children and families is of clear benefit in that:

- Parents and children are often very aware of what they need. Parents and children themselves may be the first people to recognise that there is a significant risk to the child's welfare.

- Children form strong bonds with those that care for them. Even when affective bonds are distorted by trauma, dysfunction or abuse, these bonds can continue to represent a degree of security for the child.

- Not all parents and carers accept professional help, or work in partnership to safeguard the child. It is therefore very important to assess the effectiveness of any intervention to ensure any 'apparent' partnership does actually result in change.

- Children and families need to understand why sharing information with professionals is necessary; they can help professionals distinguish what information is significant.

Even in cases where compulsory action is necessary, research has shown outcomes for children are better by working collaboratively with families.

Information should be given to children and families in formats that can be understood, such as free of jargon and in language appropriate for the child's age and development. Processes should be designed to empower children and families to participate. For example inviting families to attend meetings held in conference rooms may be intimidating or requesting that a child attends a meeting with many adults they have not met before may be overwhelming. If this is unavoidable then care should be taken to prepare the child and their parents / carer in advance so they know what to expect.

Where a child has a disability, it should not be assumed that child does not have the capacity to participate, although specialist forms of communication may be needed.

Confidentiality

Informed Consent / Assent

In general, consent must be obtained before passing on information regarding a child or their families from parents (and also children). This includes making referrals to other agencies.

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 caregivers prior to providing services or making a referral.

Informed assent is the expressed willingness to participate in services or provide information. For younger children who are by nature too young to give informed consent, but old enough to understand and agree to participate, the child's informed assent should be sought.

In exceptional circumstances, information can be shared against parents and children's wishes if it is considered, that it is in their best interests to do so. The reasons for doing so must be carefully explained. There is no set rule for disclosing information, but generally information should be shared when the child or another person is at risk of being harmed. Each case should be considered individually, and decisions to disclose information should be taken in conjunction with management of the agency.

When seeking consent / assent:

- The informed assent / consent process must include explaining exactly the information needs to be shared, how it will be used and by whom.
- This should be done in appropriate language and formats, giving the opportunity to ask questions.
- Even with very young children (i.e. under 5 years old), efforts should be made to share and explain information in an appropriate format.
- Children and parents should be given the opportunity to highlight any information that they do not want disclosed to any particular person.
- Ideally consent should be given in written form.

Record Keeping and Data Protection

For all cases written records need to be kept. Records must be kept in a secure environment, accessible only to those who have responsibility for the protection of children. While each agency may retain their own files there should be only one central file in each agency:

Each case should be given a unique ID number so that confidentiality can be ensured when discussing the case with people other than those involved in directly supporting the child and their family. This also ensures that files and cases do not become mixed up.

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. Agencies should make arrangements so that a child can view the information held on file if they wish.

The following data guidance on data protection is based on the concept of confidentiality, which is a central component of the principles of best interest and participation for children[2].

Confidentiality means ensuring that information disclosed is not used without their consent or against their wishes and is now shared with others without their permission, except in exceptional circumstances (i.e. where serious safety concerns are identified).

General Data Protection

- Information can be stored or transmitted verbally, on paper or electronically.
- When providing information to other agencies, the ID number should be used so that the risks of confidentiality being broken are limited.
- Sensitive data, such as names etc., should not be transmitted by email except using secure, encrypted email systems. Information should not be kept on laptops or external drives.
- All agencies holding information on children should have a written data protection policy, based on the principle of confidentiality. An obligation to uphold this policy should be written in to staff contracts.
- All staff involved in the work should be aware of the data protection protocols and the security implications of sensitive data.
- Access to information on children should be limited only to those who need to know it. Information should be passed only to a person designated to receive it, for clearly defined purposes, such as a line manager or partner agency.
- Each case should be stored in its own individual (paper or electronic) file, clearly labelled with the ID code on the outside of the file. The child's name should not appear on the outside of the file.
- Files should be kept in a secure location, accessible only to those responsible for the information. No one else should be given independent access without permission.
- Rooms and computers containing paper or electronic information should be kept securely locked when those responsible for the information are not present.
- Child protection records should be retainedat Center for Social Work database, in case the child wishes to view them either now or as an adult.

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

Section II

Case Management Roundtables / Task Forces

As mentioned previously in this Protocol a specific mechanism included within multi-disciplinary working in child protection cases in Kosovo is the **Case Management Roundtable (CMR)**, also known as the **Task Force.**

In the frame of the professional growth and capacity building within the CMR, each of CMR members should participate in trainings designed for enhancing the quality of services provided by the CMR and the functioning of the CMR.

In addition agencies participating in the CMR are required to participate and engage in advocacy activities for the CMR and to lobby for support of the CMR process. For example through meetings with local and central level authorities and in the preparation of brochures/leaflets on the CMR role and activities.

Purpose and Use of the CMR

The CMR is a coordination mechanism held to consider child protection cases where the risk level is **medium or high risk.**

A CMR should be held for each case medium and high risk case. CMRs should be held at least 1 time for 3 month non depending of the cases, but can also be called more frequently.

Holding individual CMRs for each case allows for the CMR to be attended by workers who have knowledge of the family. However in practice, where a number of cases need to be considered, and there are few workers and resources, it may be pragmatic to consider several cases within one CMR. This should be avoided as much as possible as it increases the risk that confidentiality will be broken unintentionally.

Convening joint meetings limits the possibility for children and their families to participate in the CMR (in line with the principles of the Protocol). This is because it may be difficult for families to avoid seeing each other while waiting to attend the meeting – again an issue for confidentiality. It should be remember that waiting to attend a meeting and then being invited in to participate when the meeting is already in session could be intimidating and disempowering for families.

In addition the CMR provides a forum for addressing wider issues relating to child protection within the (locality) and which impact on a number of cases. This could include, for example, difficulties in accessing services or advocacy regarding the use of CMRs.

The main responsibility for the functioning of the CMR lies with the relevant Director of the Center for Social Work. The CSW chairs the meeting.

Roles and Responsibilities of the CMR Members

In addition to the general responsibilities that all agencies share, CMR members have specific obligations according to their agency mandate:

Social Worker for Child Protection (Center for Social Work) coordinates and chairs the monthly meetings of the CMR. Conducts Assessment for the referred cases, gives professional opinions and ideas to care plan for the child, and carries out monitoring visits to the family. The Social Worker can also be involved in organising and providing direct services to children such as alternative care and counselling.

Probation Service Officer (Ministry of Justice) is responsible in the CMR for the management of cases of minors in conflict with the law from 14-18 years old. They follow any trial and support the implementation of measures set out by the courts / legal process in relation to young offenders. As well as contributing to the social survey and developing plans for children in conflict with the law. Please note that this work is carried out under the management and protocols of the Probation Service. Other agencies offer their support based on the needs set in the action plan.

Victim Advocate (VICTIMS ADVOCACY AND ASSISTANCE OFFICE/Office of the State prosecutor) are authorized official persons who provide support and assistance to crime victims access to justice. Victim Advocates is the authorized representative who has the authority to: notify the injured party as to the rights of his/her, and representing the interests of victims in the proceedings and the court prosecutor; and when necessary, refer the victim to other service providers. The victim advocate acts on behalf of the victim when necessary, and needed to stop violation of the rights of the victim and demanding action to guarantee their protection. Is included in the CMR with a specific remit to help coordinate with anti-trafficking police and in cases where criminal investigations and procedures are also being followed.

Anti-trafficking Police – in addition to identifying trafficked children and referring them to the CSW for further management, investigates groups involved in the trafficking. They are also involved in the placement of children in shelters in cooperation with Centers of Social Work.

Kosovo Police, Investigation Unit – Domestic Violence Police – in addition to referring cases and being involved in the assessment and development of the action plan they investigates cases. Where there are suspicions and it is difficult to verify the evidence for a criminal case to proceed they provide details of information gathered to be able to inform decisions about risk and the care plan.

The Municipal Directorate of Education – the representative of the Directorate of Education coordinates with schools in order to identify and refer cases and is involved in the school integration of the cases under the management of CMR. There main role is to coordinate the actions of the Pedagogue Psychologist/School Director/Municipal Directorate of Education with the CMR.

School Psychologist provides professional opinion and help in the treatment of cases.

Community Police helps the CMR in coordination with the Police Units which do not have representatives in the CMR. Participates in projects that are related to child protection as a partner with NGOs or other institutions that are part of the CMR.

Directorate for Health and Social Welfare supports the CMR for specific cases which require health treatment and specific social welfare help, and supports in coordination with the municipal level.

Community Office helps to identify, refer and manage cases from the RAE community in the CMR. This includes supporting monitoring visits and gathering data.

Local NGO – Offer services for cases presented in the CMR, based on the projects that they are implementing.

CPUs (Child Protection Unit - Center for Social Work) when established will be composed of child protection social workers specialised in child protection issues. Their function will be similar to that of the Social Workers in leading the monthly meetings of the l CMR and lead on follow up of cases and coordination with other CMR members.

Process of the CMR Meeting

Before the Meeting

- The Head of Social Services in close cooperation with the Case Manager and CSW Director agree the date of the meeting and send out necessary invitations and relevant information.
- A **participants list** should be prepared. For the *initial* CMR and when it is proposed to close a case all agencies should be invited. In follow up CMRs only those agencies who are involved with the family should be invited.
- **Invitations** should be sent (see Appendix 6) together with agenda for the meeting.
- The **date for the meeting** should be set in agreement with the participants, as far as this is possible.
- If agencies / members cannot attend the meeting they should notify the CSW at least 24 hours in advance and provide any additional information they may have on the case in order to feed into discussions at the meeting.

- Agencies should be sent a copy of the **assessment** at least two working days in advance of the initial meeting. This should include an-depth case analysis which identifies the identified child protection concerns, protective influences and a summary of attempts to help the family to date *(see Appendix 5 for assessment form and further information on assessment process)*.

- Where it is not possible to complete the assessment in time, for example in a high risk case, information can be provided at the meeting but this should be avoided where possible in order to give participants the time to review information. This helps to ensure that discussions at the meeting can be as meaningful as possible.

- A draft care plan / suggestions for action should be sent together with the assessment (see Appendix 7).

- For follow up CMRs members should submit a written progress report at least three days in advance of the meeting using the standard format (see Appendix 7)

- The CSW should confirm that the family and child have been notified about the meeting and their views should. They should confirm whether the family intend to attend the meeting and if so make sure that arrangements are in place in order to ensure their attendance is supported.

During the Meeting

All CMR meeting should follow the same format:

1. CSW as chair welcomes participants, explains the purpose of the meeting and gives introductions.

2. Agree who will take notes and produce the minutes of the meeting. Normally this is SWC CSW, but if this is not possible another member of CMR can minute. *See Appendix 7 for the format of the minutes, which should be used in all cases.*

3. Participants should be reminded of confidentiality rules – should share information on a 'need to know' basis, refrain from sharing 'nice to know' information.

4. All participants should be given the opportunity to participate and share their views. If the family is invited they should also be given the opportunity to participate, but this must be done in a sensitive and empowering way. The main purpose of the meeting is to share information and agree an action plan – not to 'cross examine' the family and make them justify their actions.

5. Participants consider the assessment and also provide updated information, since the situation may have changed in the meantime. This discussion should also include a discussion of the strengths and resources (i.e. protective factors).

6. Following discussion, the participants should be asked to agree the risk level for the case. If the case is judged to be no, or low risk, based on the information presented and the discussions, then the can be closed. This does not mean that further support will not be provided, but that this can be agreed with the family outside of the CMR.

7. Case manager should be appointed. This will typically be the Social Worker but another worker can be nominated to coordinate and follow up actions if this is more appropriate. For example if one member has a positive relationship with the family.

8. Plan should be developed and agreed, identifying key actions and responsibilities and timeframes. *See Appendix 7 for template.* This should also include contingency arrangements i.e. what will happen if the plan or parts of it cannot be met and alternative courses of action.

9. Agree and set time for next meeting (i.e. review CMR). This should be after one month, unless agreed otherwise at the meeting. If the review period is not one month, the reason for this should be documented in the minutes.

10. Thank participants for attendance.

After the Meeting

- CSW should produce minutes of the meeting, and agreed action plan, using the standard templates and distribute to all members *within two weeks of the meeting.*

- Case manager / CSW should ensure a copy of the minutes and any supporting documents (e.g. plan) is placed on the child's file.

- If not present at the meeting, the child and family should be notified of the outcome of the meeting by the case manager / CSW.

- Participants at the meeting should update managers and coordinate within their agencies to ensure the implementation of action points identified for their agency.

- The case manager should maintain regular contact with those named on the plan to follow up on agreed actions.

- Action points from the plan should be implemented in line with the plan. Where action points cannot be implemented in accordance with the plan, the case manager should be immediately advised.

Developing and Reviewing the Care Plan

Developing the Plan

Although the CSW will develop an initial draft plan for discussion at the CMR, this should be used as a starting point. For case discussed in a CMR participants at the meeting should develop a mutually agreed care / action plan for this case. **For this reason it is important that those attending the meeting have the authority to make decisions regarding the services that they are able to offer and the actions that they need to take.**

The care plan should outlines the steps that will be taken to:

- Ensure the child is safe and risk factors are reduced
- Promote the best interests and meet the holistic needs of the child
- Provide support for the family so that they can appropriately care for and protect the child

During the meeting the assessment and any other information updates should be reviewed and a collective decision on the actions needed to reduce risk, keep the child safe and ensure their needs are met considering:

- How can needs be most effectively met
- Contingency and alternative courses of action in case it is not possible to carry out an item on the plan
- Timescales for completion of tasks and also responsibilities
- Review date

The plan should consider how the needs of the child will be met in the short, medium and long term.

Children and family members know best what the situation is in their family, and without their agreement any plan is likely to fail. Therefore, it is good practice to invite children and parents to participate in developing the plan. If they do not attend the CMR, then their views and ideas should be sought beforehand so that they can participate in the planning process.

Decisions made should be recorded on the care plan template (*see Appendix 7*) and a copies given to those family, all those participating and kept on file.

Review of Care Plan

In addition to the ongoing monitoring of the care plan by the case manager, as part of ongoing liaison with members of the members of the CMR, a formal review of the care plan should be conducted on a regular basis at a CMR. In general the CMR review should take place monthly, unless specified and agreed otherwise at the initial CMR.

Ideally only those people who are actually providing services to the child or their family, or who can speak with knowledge about the case should attend the review, otherwise a larger number of people will reduce the meetings' efficiency.

The child and family should also be involved in the review. If they are not able to participate in the CMR, then their views should be sought by the case manager *before* the review.

The action points identified in the care plan should be considered in terms of whether they are still relevant and if they are being implemented – and any necessary adjustments made. The review meeting should also consider if there are any additional needs for the child (and how to address these) and to the level and nature of risks.

The care plan should be updated in accordance with the review and a copy distributed to members and the family *within one week* of the date of the CMR. A copy should also be given to the child and family.

Procedure for Closing Cases

Cases should be closed only in agreement with the members of the CMR. Before closing the case the views of the child and family should be sought.

The decision to close a case, and the reasons for it should be recorded on the cases closure form (*see Appendix 7)*, with a copy of the form being placed on the child's file. Closing a case does not mean that work stops with the child and the family. Other agencies and the Social Work Centre may continue to provide support. However closing the case signals that the case is no longer being managed under the framework of the CMR.

Circumstances when it is appropriate to close the case include:

- When the child is over 18 years old
- When the interventions implemented have reduced the level of risk to low / no risk
- When the child has been removed from the situation and there is no likelihood / plan for the child to return before they are 18 years old
- If the child moves / dies

Learning From Practice

Within the CMRs a lot of problems will be discussed. For instance substance abuse, street children, sexual abuse and domestic violence. The CMR members should evaluate these issues and in a separate review meeting discuss what can be learned from the way these problems were solved. This review meeting should be held every six months with the purpose being to identify lessons learnt which can be shared within Kosovo. This includes both to be able to improve the knowledge and practice of workers, and also for use to inform advocacy and policy development.

Definitions

Abuse: child abuse is a deliberate act of ill treatment or omission that can harm or is likely to cause harm to a child's safety, wellbeing, dignity and development. Abuse includes all forms of physical, sexual, psychological or emotional ill treatment that results in harm or is likely to cause harm. Harm can take many forms, including impacts on children's physical, emotional and behavioural development, their general health, family and social relationships, self-esteem, educational attainment and aspirations for the future.

Alternative care: care that is provided when the child's own family is unable, even with appropriate support, to provide adequate care for the child, or abandons or relinquishes the child. It may take the form of informal or formal care, including kinship care, foster care, other forms of family-based or family-like care placements, residential care, or supervised independent living arrangements.

Child: any person under the age of 18 years old.[3]

Child's guardian: a person who has been formally recognized under national law as responsible for looking after a child's interest when the parent/caregiver of the child do not have parent/caregiver responsibility over him or her or have died.

Child protection: the prevention of and response to abuse, neglect, exploitation of and violence against children.[4]

Children in conflict with the law: children who come into conflict with the justice system as a result of being suspected, accused or convicted of an offence.

Children in contact with the law: is the general term for all children in contact with the justice system. This includes children in conflict with the law and child victims or witnesses.

Children without parent/caregiver care: all children not living in the overnight care of at least one of their parents/caregivers, for whatever reason and under whatever circumstances. Children without parent/caregiver who are outside their country of habitual residence or victims of emergency situations may be designated as unaccompanied or separated.

Confidentiality: an ethical principle associated with medical, legal and social service professions. Maintaining confidentiality requires that service providers protect information gathered about clients and agree only to share information about a client's case with their explicit permission. Maintaining confidentiality about abuse means service providers never discuss case details with family or friends, or with colleagues whose knowledge of the abuse is deemed unnecessary. There are limits to confidentiality while working with children.[5]

Disability: is an evolving concept that results from the interactions between persons with impairments and attitudinal and environmental barriers that hinder their full and effective participation in society on an equal basis with others.[6]

3 Convention on the Rights of the Child 1989, or UNCRC, article 1.
4 Global CPWG definition: www.cpwg.net.
5 Caring for Child Survivors of Sexual Abuse. IRC/UNICEF. 2012.
6 Preamble of the United National Convention on the Rights of Persons with Disabilities. 2006.

Emotional abuse: emotional or psychological abuse is the persistent emotional maltreatment of a child such as to cause adverse effects on the child's emotional development and psychosocial wellbeing. It includes humiliating and degrading treatment (e.g. name-calling, constant criticism, belittling, persistent shaming, confinement and limiting social interaction).

Gender-based violence (GBV): GBV is an umbrella term for any harmful act that is perpetrated against a person's will, and that is based on socially ascribed (gender) differences between males and females. The nature and extent of specific types of GBV vary across cultures, countries, and regions.[7]

Informed assent: the expressed willingness to participate in services. For younger children who are by definition too young to give informed consent, but old enough to understand and agree to participate in services, the child's 'informed assent' is sought. Informed assent is the expressed willingness of the child to participate in services.[8]

Informed consent: 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/caregivers are typically responsible for giving consent for their child to receive services until the child reaches 18 years of age.[9]

Neglect: persistently failing to provide for, or secure for a child, their basic physical, developmental or psychological needs, whether deliberately, or through carelessness or negligence. Neglect is sometimes called the 'passive' form of abuse, as it relates to the failure to carry out some key aspects of care and protection resulting in the impairment of the child's health or development. It may include unresponsiveness to meet the child's most basic emotional needs. Neglect does not include situations of poverty, where a parent/caregiver cannot afford to provide for their child but is trying to do so.

Perpetrator: Person, group, or institution that directly inflicts or otherwise supports violence or other abuse inflicted on another against his/her will.[10]

Physical abuse: the use of physical force to cause actual or likely physical injury or suffering (e.g. hitting, shaking, burning, torture, stoning, etc.). Physical abuse can take place in the home, the community and in schools.

Psychosocial support: support that aims to protect or promote psychosocial wellbeing and/or prevent or treat mental disorder.[11]

Trafficking: recruiting, transporting, transferring, harboring or receiving a person through the use of force, coercion or other means, for the purpose of exploiting them. For example, a child has been trafficked, if he or she has been moved within a country or across borders, whether by force or not, with the purpose of exploiting the child.

Unaccompanied child: a child who has been separated from both parents/caregivers and relatives and who is not being cared for by an adult who, by law or custom, is responsible for

7 IASC Guidelines for Gender-based Violence Interventions in Humanitarian Settings. IASC. 2005.
8 Ibid
9 Caring for Child Survivors of Sexual Abuse. IRC/UNICEF. 2012.
10 IASC Guidelines for Gender-based Violence Interventions in Humanitarian Settings. IASC. 2005.
11 IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings. IASC. 2007.

doing so[12]. This means that a child may be completely without adult care, or may be cared for by someone not related or known to the child, or not their usual caregiver e.g. a neighbour, another child under 18, or a stranger.

Violence: the intentional use of physical force or power, threatened or actual, against a child, by an individual or group, which either results in or has a high likelihood of resulting in actual or potential harm to the child's health, survival, development or dignity. This can also include self-inflicted violence, such as self-harm or suicide.

Best interest of the child: broadly describes the wellbeing of a child. Wellbeing is determined by a variety of individual circumstances, such as the age, the level of maturity of the child, the presence or absence of parents/caregivers, the child's environment and experiences. In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration.[13]

12 Interagency Guiding Principles on Unaccompanied and Separated Children.
13 Article 3 UNCRC.

Appendices

General information:

Appendix 1 Task Force (CMR) Internal Regulations
Appendix 2 Manifestations of abuse
Appendix 3 Signs & symptoms of possible abuse
Appendix 4 Normal developmental milestones
Appendix 5 Assessment process

Forms and Templates:

Appendix 6 Invitation/Agenda
Appendix 7 Template of Raporting/Minutes Meetings of CMR

Appendix 1
Task Force (CMR) Internal Regulations

Task Force

Internal Regulations

- With the aim of protecting children through a case management multidisciplinary roundtable called Task Force;
- In line with the Convention of the Rights of the Child, article 3 (Best Interests of the Child), article 6 (Survival and Development), article 19 (Protection of Abuse and Neglect), article 24 (Health and Access to Health Services), article 27 (Standards of Living), article 28 (Education), article 34, 35, 36 (Sexual Trafficking and Exploitation); and
- In line with the article 9.1 and 9.2 of the Law No. 02/L-17 "On Social And Family Services"[14], its members today, on the _____, consent to this Internal Regulation, with focus on the organization, coordination, cooperation, sharing responsibilities and finding solutions by protecting the best interests of children.

Article 1
Purpose of the Internal Regulation

This Internal Regulation aims to define the purpose of establishing the Task Force and its form of organization, coordination and functioning. Through the Task Force, it is aimed to also determine its structure through exactly defining its composition, the role, duties and responsibilities of each member, the confidentiality of the treated cases, the specific steps that is needed to be taken for preparing and conducting the meetings and also some other additional administrative tasks.

Article 2
Purpose of the Task Force

The Task Force is a case management multidisciplinary roundtable, whose main goal is the Protection of Children and promoting the UN Convention on the Rights of the Child (CRC) through the Universal Wellbeing Indicators of safe, healthy, achieving nurtured and inclusion with the implementation of the following steps: case identification, case referral and case management of children in medium risk and/or high risk. The criteria of medium/high risk is defined based on a detailed and combined assessment of three main factors of a child's situation: risks, vulnerabilities and protective factors.

14 Law Nn. 02/L-17 ON SOCIAL AND FAMILY SERVICES (in process of review) Article 9 - 9.1. In all matters concerning the provision of services to children and to families the best interests of the child shall be the first and paramount consideration. 9.2. In cooperation with families, communities, Non-Government Organizations and other statutory bodied, a Municipality provides social care, counseling and, in exceptional circumstances, material assistance to children and their families who are in need and residing in, or are found in its territory, based on their assessed need for such services and the Municipality's ability to reasonably provide them.

- The case identification should be done by each of member of the Task Force, within their respective institutions and their mandate.
- Each member is obliged to refer the identified cases to the Task Force, accompanied with all the necessary information.
- After an initial assessment regarding a child's situation based on the CRC, through the Child Universal Wellbeing Indicators which are; Safety, Health, Achieving, Nurture and Inclusion, its members need to assess the case according to the criteria of medium risk/ high risk. If a case is accepted in the Task Force, an individual action plan is compiled in accordance with the CRC, through the wellbeing indicators. Based on the agreed action plan and in order to protect the child, the Task Force members offer all the necessary services from their respective agency for each case, while protecting the best interest of the child.

Article 3
Composition of the Task Force

The Task Force is composed of representatives from the following institutions:

- The Municipal Directorate of Health and Social Welfare – Social Worker
- The Center for Social Work – Social Worker
- The Municipal Directorate of Education – Education Officer
- The School Psychologist/Pedagogue
- The Probation Service of Kosovo – Probation Service Officer
- The Division for Protection and Help for Victims – Victims Advocate
- The Kosovo Police with three representing sectors:
  - The Community Police – Representative
  - The Investigation Sector of Trafficking with Human Beings – Representative
  - The Investigation Sector of Domestic Violence – Representative
- The Family Medical Center – Doctor
- The Mental Health Center – Psychiatrist
- The Municipal Community Office – Community Officer
- Residential Institutions - Representative
- Non-Governmental Organizations working in child protection field Representative(s)
- The Municipal Office for Human Rights – Child Rights Officer and
- Terre des hommes Foundation Representative.

Regardless of its current composition, the Task Force remains an open multidisciplinary group to other relevant professionals working in child protection.

Article 4
Target Group for the Task Force

All children (from 0 to 18 years old) who are in medium or high risk of abuse, neglect, trafficking, economic or sexual exploitation and in conflict with the law. The criteria of medium/high risk are defined based on a detailed and combined assessment of needs and risk taking in to consideration vulnerabilities and protective factors.

The protection, integration and wellbeing of the children will be addressed in a sustainable manner, by supporting their families and the other caregivers. Based on the specific and individual necessities of a child and his/her family, this support by professionals aims to provide services for the child's/family's wellbeing and development.

Article 5
Duties and Responsibilities of the Task Force Members

Through this Internal Regulation, the Task Force members commit to engage toward fulfilling the following duties and responsibilities:

- Each of the Task Force members is obliged to respect and implement each Article of the Internal Regulation.
- Each of the Task Force members is obliged to continuously coordinate and cooperate with all the other members for each of the cases presented during a meeting.
- Within his/her institution and its mandate, and when this institution cannot provide alone all the necessary services in accordance to the best interests of the child, each of the Task Force members refers any new identified case of a child in CSW,based on evaluation case in medium/high risk to the Task Force.
- The Task Force jointly assess the case at hand (see below), agrees on a joint plan of action and divides roles and responsibilities accordingly.
- Each of the Task Force members shares the information they possess regarding a specific case, with the other members of the Task Force, in order to offer an appropriate assessment of the case and draft an action plan foreseen all the required services.
- Each of the Task Force members suggests actions for each of the cases, based on their responsibilities, within the mandate of the institution s/he represents and taking into account the best interests of the child as paramount.
- Each of the Task Force members commits and engages in the duties and responsibilities assigned to him during the Task Force meetings and in implementation of the Action Plan.
- Each of the Task Force members informs his/her hierarchy regarding the latest developments and actions taken for the cases discussed in the Task Force.
- Each of the Task Force members is obliged to compile a summary of the achieved - outcomes from their actions for a specific case and to send these outcomes to the Task Force Leader, no later than 3 (three) days before the meeting.
- Each of the Task Force members is obliged to regularly use all the common documents of the Task Force, which have been previously approved during the Task Force meetings.
- In the frame of the professional growth and capacity building within the Task Force, each of the Task Force members is obliged to take part in different trainings which are designed with the purpose of enhancing the quality of services provided by the Task Force.
- Each of the Task Force members is obliged to participate and engage in advocacy activities for the Task Force institutionalization and to lobby in this regard, through meetings with local and central level authorities and when required in the preparation of brochures/leaflets on the Task Force role and activity.
- The Task force shall close the case when it is considered that all needed services are provided and where the case passed from medium/high risk to low-risk, based on:
    - An complete assessment of the universal well-being indicators especially those of welfare, safety and health;
    - An assessment of the family situation;
    - No further need identified for interdisciplinary coordination to provide services.

The case shall be transferred to the case manager from the relevant institution, which will continue to monitor the well-being of the child and his/her family.

Article 6
Duties and Responsibilities of the Task Force Coordinator

Through this Internal Regulation, the Task Force coordinator in addition to his/her obligations as a Task Force member, assigned in Article 4, commits to engage for the fulfillment of the following duties and responsibilities:

1. The coordination of the Task Force meetings is organized and conducted by the Social Worker appointed by the Center for Social Work.
2. The Task Force coordinator is obliged to prepare the agenda of the Task Force meeting to send the agenda to all the other Task Force members no later than 3 (three) days before the meeting and to prepare the Task Force Report/Minutes of Meeting and send it to all the other Task Force members.

The duties and responsibilities of the Task Force coordinator will be performed with the support of the "Terre des hommes" Foundation, until gaining the institutionalization of Task Forces.

After reaching institutionalization, these duties and responsibilities will remain under the full competence of the Task Force coordinator – the Social Worker appointed by the Center for Social Work.

In the future, the coordination of the Task Force can be assigned to any other Task Force member (e.g. Child Rights Officer).

Article 7
Regular and Extraordinary Meetings

Task Force meetings will be held based on cases evaluation in CSW in medium/high risk according to the announcement of the Task Force Coordinator. However, according to the various needs that may arise, extraordinary meetings of the Task Force can be organized, upon the request of one or more Task Force members. The regular and extraordinary Task Force meetings are considered valid and can be held if the meeting is attended by all the members who are directly involved in the case or cases which are going to be discussed.

Article 8
Attendance in the Task Force Meetings

In order to ensure Task Force is able to function, its members are obliged to regularly attend the Task Force meetings. In the case of their inability to attend one of the meetings, they are obliged to appoint another representative from the institution they represent, to replace them to take part in the meeting. The representative who replaces the permanent member of the Task Force should be informed in advance on the cases that will be discussed at the meeting.

Where there is no participation from a respective institution, the director of this institution should inform the Task Force coordinator as soon as possible before the Task Force meeting.

Article 9
Communication

For all the Task Force meetings, the coordinator of the Task Force is obliged to appoint one of the Task Force members to keep a specific record of the meeting, with the date, the venue, the number of participants.

Article 10
Confidentiality

All the information and data about children should be protected. For this purpose, all the cases managed in the Task Force will be identified with a specific and unique code for each of them. Each document regarding these cases will have its own code instead of the name when it is used in electronic correspondence or when such document is presented out of the Task Force for data protection and confidentiality. Only the Task Force members should have access to various Task Force documents regarding the cases.

Article 11
Entry Into Force

This Internal Regulation shall enter into force immediately after its approval and signature by all the Task Force members.

Appendix 2
Manifestations of Abuse

Manifestations of abuse include

Physical Abuse

- Smacking
- Punching/beating
- Burning (e.g. with cigarette)
- Biting
- Pulling hair
- Hitting a child with an object
- Leave a child in uncomfortable posture or environment for an extended period of time
- Force a child to work in poor working conditions, or inappropriate for a child's age
- Harmful initiation ceremonies to someone new
- *Bullying (can also be emotional)*

Emotional Abuse

- Isolating or excluding
- Stigmatising
- Failure to provide supportive environment
- Main caregiver(s) does not respond to a child's emotional needs
- Humiliation and persistent teasing (such as calling hurtful names)
- Bullying
- Excessive, disproportionate scolding, shouting, bickering and possibly swearing at a child
- Making comments that show discrimination or humiliate a child
- Spreading rumours
- Threatening

Neglect

- Inattention/omission of care despite available resources
- Failure to supervise and protect children from harm

Sexual Abuse

Involvement of a child in a sexual activity that s/he does not fully comprehend, is unable to give informed consent to, or is not developmentally prepared for, such as

Contact

- Kissed or held in a sexual manner
- Touched and fondled in genital areas
- Forced to touch another person's genital areas
- Forced to perform oral sex
- Vaginal or anal intercourse
- Vaginal or anal penetration with object or finger
- Incest
- Sex with animals

Non-contact

- Obscene calls/obscene remarks on computer or in written notes
- Virtual sex
- Online sexual solicitation
- Voyeurism
- Exposed to or photographed for pornography
- Sexually intrusive questions or comments
- Forced to self-masturbate or watch others masturbate
- Indecent exposure

Appendix 3

Signs & Symptoms of Possible Abuse

Signs & Symptoms of Possible Abuse	
Physical Abuse:	
Physical Indicators include	• Suspicious bruises or marks especially on parts of the body not easily injured through normal play; noticed after a child has not been seen or after the weekend • Scolds and burns from hot water • Burns from cigarettes, especially on the tongue, palm, arms, legs, back or backside. • Burns that resemble shapes of objects e.g. electrical elements, light bulbs, irons, electric fires • Unexplained / multiple fractures, broken bones or sprains • Babies who are not mobile with fractures • Unexplained scratches or lacerations in or around the: • mouth, lips, eyes, ears, neck or genital organs • Unexplained abdominal injuries such as swelling, vomiting or blood in faeces or urine
Behavioural Indicators include	• Child believes he/she deserves to be punished • Careful and watchful in the company of adults • Extremes of behaviour - aggressive or withdrawn • Sudden changes in behaviour • Scared to go home • Empty or frozen look • Lacks interaction (for babies) • Low self esteem • Reports being harmed by his/her parent(s)
Behaviour / Attitude of the Care Taker include	• Does not seem concerned about the injuries • Provides false information on how the wounds were inflicted • Uses a harsh discipline for the misbehaved child and inappropriately to the age and child's level of understanding • Has unrealistic expectations about the child • Has negative perceptions about child, considers that they do everything wrong • He/she has severe mental health problem that is not controlled • Not emotionally stable • Misuses alcohol and other substances • Confesses to have been abused when a child
Sexual Abuse:	

Signs & Symptoms of Possible Abuse	
Physical Indicators include	• Difficulties in walking or sitting still • Pregnancy • Masturbation (in young children) • Pain on urination or defecation • Bruises, bleeding or tears to the genital organs, the vagina or anus • Oral infections in children • Sexually transmitted diseases in children and adolescents • Sexualized play • Lack of sexual inhibitions towards adults • Return of wetting and soiling after the child has gained control of these bodily functions
Behavioural Indicators include	• Withdrawn or overtly affectionate to adults and/or strangers • Inappropriate sexual behaviour and knowledge • Poor relationships with peers • Frequently runs away • Self-harms • Abuses alcohol or drugs • Dramatic change in school performance; school grades fail, unjustified absences (if attending school) • Depressed • Attempts to commit suicide • Poor or disturbed sleeping patterns, including: bad dreams, nightmares, sleeplessness • Eating disorders, bulimia, anorexia • Low self esteem • Lack of trust in others • Reports that he/she has been sexually interfered with Confused boundaries between appropriate behaviour of a child and/or adult

Signs & Symptoms of Possible Abuse	
Behaviour / Attitude of the Care Taker include	• Parent/adult continuously gives presents to one child in the family • Parent/adult suffers from alcohol or narcotic abuse • Parent/adult does not accept responsibility for the abuse of the child places blame onto the child and relates it to the child's behaviour • Parent/adult has poor/limited control over the own impulses/ desires • Marital problems • Over controls the child's movements, opportunities to speak with others or mix with friends • Boundaries between adults and children are vague and frequently crossed • Parent/adult has been sexually abused during his/her own childhood
Emotional Abuse:	
Physical Indicators include	• Speech disorders or delayed speech • Delayed or stunted physical development / failure to thrive • Hyperactive behaviour ; limited attention span • Withdrawn, anxious, isolated • Does not make eye contact • Empty or frozen facial appearance • Lack of emotions or mixed emotions • Seeks attention from anyone / needs constant approval • Picks at own skin until it is sore or bleeds • Soiling or wetting • Nightmares
Behavioural Indicators include	• Sleeping & eating disorders • Unusual fears and anxieties • Extremely obedient or passive • Aggressive • Clingy or does not allow others to get close to him/her • Introvert • Believes others do not like/love him/her • Makes negative comments about him/herself and his/her behaviour ("I never do things right") • Lack of trust • Believes he/she should be punished • Attempts suicide or has suicidal thoughts

Signs & Symptoms of Possible Abuse	
Behaviour /Attitude of the Care Taker include	• Blames/teases and denigrates the child • Is cold and distant and does not show the child affection or warmth • Doesn't show a positive attitude or behaviour towards the child • Provides negative descriptions or explanations about the child's behaviour • Treats the children in the family unequally • Is not interested in the child's problems or minimizes them • Has alcohol or substance dependency • Parent/adult admits that they do not know how to show positive affection to the child • Parent/adult is in an abusive relationship • Unable to meet the child's need or respond to them consistently or appropriately • Parent/adult puts his/her needs/desires above those of the child • Gives harsh and/or destructive answers to the child's requests • Threatens and scares the child • Threatens the child with sending him/her away or with severe punishments • Is not aware of the basic needs of the child or believes the child can meet his/her own needs by him/herself • Believes the child is responsible for the negative reactions of the parent/adult • Impulsive unable to be consistent in his/her responses to the child • Blames the child for his/her problems • Feels out of control, has no support networks or coping skills
Neglect:	
Physical Indicators include	• Underweight or short for his/her age and stage of development including delayed speech • Failure to thrive • Malnourished or always hungry • Poor or a lack of daily hygiene, dirty, smelly • Inappropriately dressed for the weather, housing conditions or activity • Lack of medical care and medication if required • Lack of supervision during play, around an open fire or wood stove, near water etc. • Lack of boundaries, social rules or daily routines • Abandonment / Unaccompanied • Hard labour

Signs & Symptoms of Possible Abuse	
Behavioural Indicators include	• Steals or begs for food • Often falls asleep during the day • Limited or poor attendance; comes late and goes early • Appears sad, alone or unhappy • Difficulty in making and keeping friends • Reluctant to talk about home life • Behaviour problems • Seeks adult company or praise • In trouble with the law • Drug or alcohol use • Inappropriate need for affection, clingy or touching • Undertakes the responsibilities of adults • Murmurs, moans or sings • Hangs around school or other centres • Has thought or attempted suicide • Regressive behaviour , such as sucking his/her fingers, soiling, wetting
Behaviour / Attitude of the Care Taker include	• Parent/adult has a chronic disease or disability • Parent/adult is depressed or suicidal • Parent/adult shows little understanding of the needs of the child or how he/she can meet them • Puts his/her feelings and needs before that of the child • Parent/adult had a disruptive childhood or was neglected as a child • Suffers from a mental illness or mental disability • Abuses alcohol or drugs

Appendix 4

Normal Developmental Milestones

While every child is an individual and will develop at slightly different ages, most children normally achieve certain key developmental stages at similar ages. These are often called **developmental milestones.** Although the failure to meet developmental milestones is not necessarily a concern, if the milestone is severely delayed (by several months) or where multiple milestones are missed, it may indicate there is cause for concern – either because the child has special needs and needs additional support, or because they are being abused / neglected and the failure to meet the developmental milestone is a symptom.

Obviously many of the skills are heavily dependent upon the child being in an environment where they are encouraged and taught – for example reading. The table below outlines key milestones that children can be expected to reach, assuming they are given the necessary support.

	Key developmental milestones
Infancy – birth to 2 years	• Displays social smile • Rolls over by self • Able to sit alone, without support • Babbling • Eruption of 1st tooth • Pulls self to standing position • Walks while holding on to something (e.g. hand) • Says for example mama and dada, using terms appropriately • Able to drink from a cup • Understands "NO" and will stop activity in response • Walks without support • Uses up to 8 words and understands simple commands • Starts to try to feed self • Can name pictures of common objects and point to body parts • Imitates speech of others, "echoing" word back • Able to state name

Key developmental milestones	
Early childhood 3 – 6 years	• Learns to take turns (if directed) while playing with other children • Able to feed self neatly, with minimal spilling • Able to run, turn and walk backwards • Able to draw a line and circle (when shown one) • Recognises and labels colours appropriately (if taught) • Dresses self with only minimal help • Learns to share (without adult direction) • Able to draw stick figures with 2 to 3 features for people • Hops on one foot • Catches a bounced ball • Understands differences in size concepts • Enjoys rhymes and word play • Enjoys doing most things independently, without help • Understands time concepts • Begins to recognise written words -- reading skills start (if taught) • Recognises gender differences
Middle childhood 7 – 12 years	• Understands and able to follow sequential directions • Beginning skills for team sports (football etc.) • Loses "baby" teeth and erupts permanent teeth • Routines important for daytime activities • Reading skills develop further (if taught) • Peer recognition begins to become important • Girls may begin to show growth of armpit and pubic hair, breast development • Menarche (1st menstrual period) may occur in girls
Adolescent 13 to 18 years	• Boys show growth of armpit, chest, and pubic hair; voice changes; and testicular/penile enlargement • Girls show growth of armpit and pubic hair; breast development; menstrual periods • Adult height, weight, sexual maturity reached • Understands abstract concepts • Peer acceptance and recognition is importance • Makes concrete plans for future / life as an adult

Appendix 5
Assessment Process[15]

This is a major step in case management and should be completed with care. This information is included here in order to help members of the CMR understand how the assessment has been completed.

In child protection cases an assessment seeks to identify:

- The holistic needs of the child, in relation to their age and development and in consideration with the dimensions of **wellbeing**
- Risks to the child in the short, medium and long term
- The strengths and resources of the child, family and community

The assessment is not the same as an investigation that may be undertaken by the police so that an offender can be prosecuted. **This assessment is primarily focused on the needs of the child (and their family) and their safety.**

The assessment should be completed **within 14 working days from referral.**

The CSW / SW should coordinate and complete the assessment, supported by the Case Management Manager / Supervisor following the steps outlined for the assessment process.

During the assessment process the child and family must be involved. All agencies working with the child, or who may have knowledge of the family should also be requested to provide information in order to feed into the assessment process.

All assessments should follow the same stages:

Step One	Assessment Planning
Step Two	Gathering Information
Step Three	Verifying Information
Step Four	Analysis

STEP ONE: ASSESSMENT PLANNING – This stage involves deciding what information is needed, who is going to get it and from where and when. As mentioned previously in an immediate or high risk case, or where the situation is very complex, it may be useful to call together a strategy meeting of the agencies who already have contact with the family to help plan the assessment and share activities.

STEP TWO: GATHERING INFORMATION - This stage involved gathering all information that may be relevant. There are a number of different ways that this can be done including:

15 Note this is based upon the Working Protocol for Case Management developed in Albania

- Checking information held on file / from previous reports
- Interviews and meeting with people who have been working with the family
- Interviews with family members
- Interview with the child
- Interviews with the local community / village committee members etc
- Family observations (to assess the way the family relates to each other / dynamics)
- Home visits (to check the home environment of the child)

Confidentiality is critical and it is important that those carrying out the assessment do not share information outside or gossip!

STEP THREE: VERIFYING INFORMATION – Often when undertaking an assessment different information / stories are told. It is important to check with others to make sure that the information is correct. For example, if the parent says that the child is always badly behaved it would be useful to check with the other family members or an NGO who has been working with the family to see if they have the same idea.

STEP FOUR: ANALYSIS – The final stage in the assessment is analysis. This involves evaluating all the information in order to determine the situation for the child and the risks to which they are exposed in order to make a more rigorous determination of the level of risks and the needs of the child. Sometimes it is difficult to analyse the information, and in which case this step can be left for discussion and agreement at the CMR.

When analysing the information obtained through the assessment, *needs* rather than services should be identified. For example the need is for education, school is a service. This is critical so that during the planning stage those developing the care plan can be given the opportunity to think broadly about how needs can be met. This is important in locations where resources are limited as it can facilitate the identification of creative solutions, including those from the community.

Within the comprehensive assessment, a number of focused or specific assessments may also be undertaken – for example a specialist medical assessment or a focused assessment on the learning needs of the child carried out by a psychologist.

Throughout the assessment process it is essential to continually consider the risk to the child – and if information comes to light that suggests the child may be at high risk or immediate danger then urgent action may be necessary to keep the child safe while the assessment is completed.

Appendix 6
Invitation/Agenda

- The assessment of the situation
- The identification and the referal of cases for management to CMR; the presentation of the case by the case manager and the share of responsibilities.
  - Case description
  - The categorization of the case
  - Action Plan
- Other
- The arrangement of the next meeting

Appendix 7

Template of Raporting/Minutes Meetings of CMR

Logo of Respective Municipality

Client's name and surname:_____

Referred by (case manager): _____

Medium High Risk Case

The date of the meeting of CMR (Case Management Round Table)

_____

Information about the case / Assessment of the case by CPSW (Child Protection Social Worker)

_____

_____

_____

_____

Actions undertaken by case manager (CSW)

_____

_____

_____

_____

Description of the case during the meeting (minutes of the meeting):

_____

_____

_____

_____

_____

_____

_____

Unified Action Plan

_____

_____

_____

_____

Review: (results presented by stakeholders based on Action Plan):

_____
_____
_____
_____

Case closure

_____
_____
_____
_____

Closure date: _____

The person responsible for the case: _____

Participants:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

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