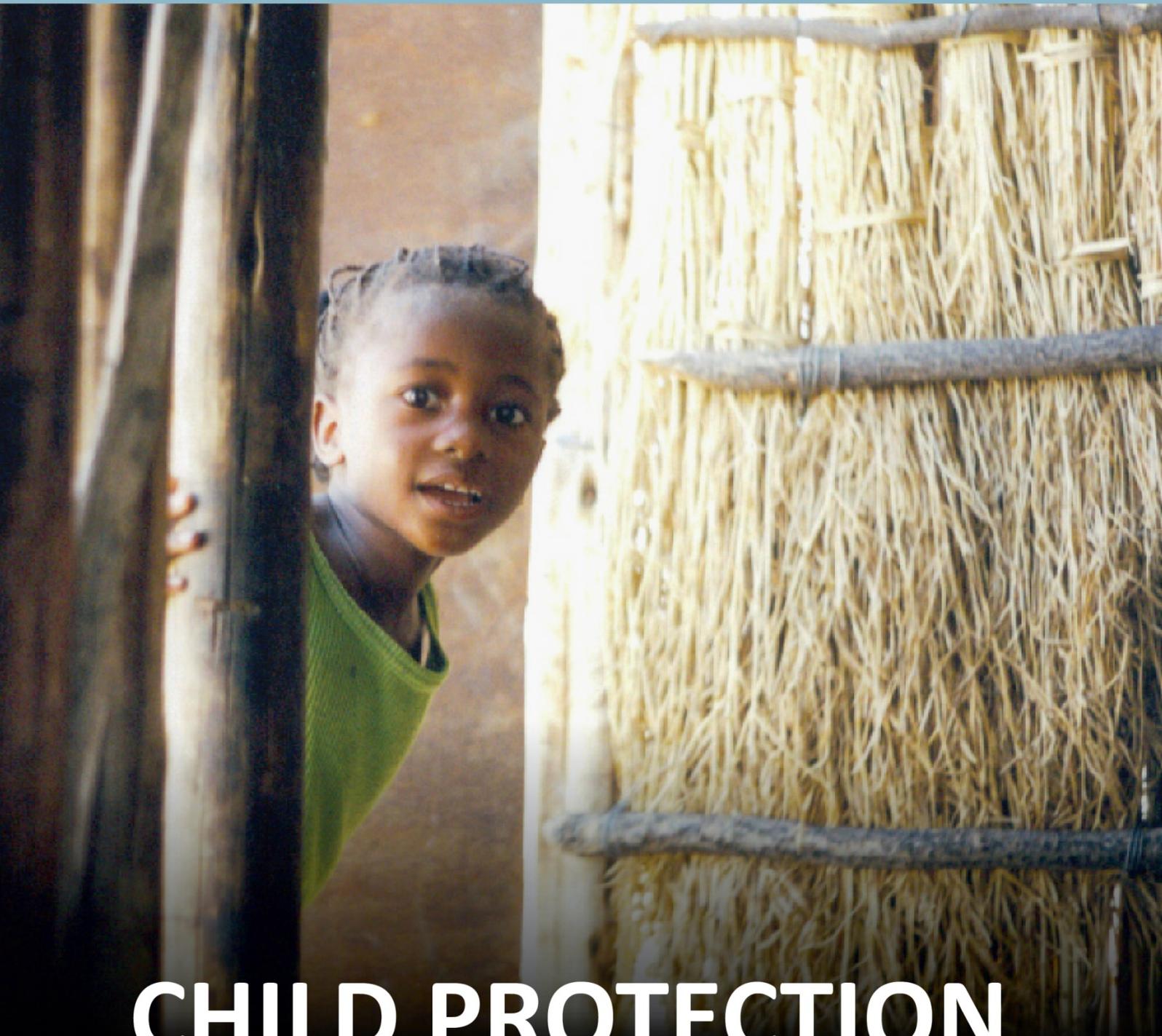




Ministry of Gender Equality and Child Welfare



# CHILD PROTECTION

CASE MANAGEMENT OPERATIONS MANUAL



**4Children**  
Coordinating Comprehensive Care for Children

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Coordinating Comprehensive Care for Children (4Children) is a five-year (2014–2019), USAID-funded project to improve health and well-being outcomes for Orphans and Vulnerable Children (OVC) affected by HIV and AIDS and other adversities. The project aims to assist OVC by building technical and organizational capacity, strengthening essential components of the social service system, and improving linkages with health and other sectors. The project is implemented through a consortium led by Catholic Relief Services (CRS) with partners IntraHealth International, Pact, Plan International USA, Maestral International and Westat.

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## Acronyms

<b>ARV</b>	Antiretroviral therapy
<b>CBO</b>	Community-based organization
<b>CCPA</b>	Child Care and Protection Act, No. 3 of 2015
<b>CCPF</b>	Child Care and Protection Forum
<b>CM</b>	Case management
<b>DCW</b>	Directorate of Child Welfare
<b>ECD</b>	Early childhood development
<b>GBV</b>	Gender-based violence
<b>MGECW</b>	Ministry of Gender Equality and Child Welfare
<b>MHAI</b>	Ministry of Home Affairs and Immigration
<b>MOHSS</b>	Ministry of Health and Social Services
<b>NAC</b>	National Agenda for Children
<b>NGO</b>	Non-governmental organization
<b>OVC</b>	Orphans and vulnerable children
<b>PEI</b>	Prevention and early intervention
<b>PSS</b>	Psychosocial support
<b>PTF</b>	Permanent task force
<b>SOP</b>	Standard operating procedure
<b>UNAM</b>	University of Namibia

## Foreword

The operations manual is aligned with MGE CW commitment to social work and overall aims of the Namibian government to invest in quality work to protect and care for children. In addition, the operations manual is aligned with the UN Convention of the Rights of the Child, the African Charter for the Rights and Welfare of the Child and Namibia's Child Care and Protection Act, No.3 of 2015.

Case management is an approach at the core of social work. Case management is the process required for improving the quality of life for vulnerable children in need of care and protection. This manual is intended to support social workers in their case management role and reduce overall workload by ensuring case management processes are conducted efficiently with best outcomes for children.

The MGE CW seeks to create integrated systems and this operations manual supports this integration. The case management guidance and tools supports working together, to maximise effort and care. The overall result of an effective case management system should be to support clients holistically and ensure that they receive complementary interventions to improve their wellbeing. This needs to be done in a way that ensures quality. Having one set of case management guidance and tools aims to facilitate the processes and create uniformity throughout the country in the practice of social work. The goal is to have all government social workers receive the same training and increased skill sets aligned with UNAM's new social work curriculum on case management. The guidance and tools are for social workers to help them conduct their work as well as for them to offer supportive supervision to other social workers in the field to prevent saturation and burnout.

Having consistent and uniform social work case management approaches, job aids and documentation tools aim to assist social workers with ongoing case management efforts (guide assessments, guidance on how to prioritise risk and determine what requires immediate action) as well as with monitoring and evaluation (data collection).

This document, comprising of background information, standard operating procedures with documentation tools and job aids, aims to support social workers in their daily work to effectively support children and families with user friendly guidance adapted to different issues and situations, including:

- An overview of the policies and strategies that inform case management;
- Principles that inform case management;
- A list of all the functions required of a social worker, divided into statutory and non-statutory functions, related to case management;
- A complete set of case management documentation tools, with accompanying guidance on how and when to complete the forms;
- Job aids to support case management including supportive supervision and monitoring tool.

These tools are complementary to the updated Child Care and Protection Forum Guidelines which provides operational guidance and a set of documentation tools for community stakeholders.



**Ms. Wilhencia Uiras**

*Permanent Secretary*

*Ministry of Gender Equality and Child Welfare*



## Definitions of key terms

**BEST INTERESTS OF THE CHILD:** balancing all the different elements that inform a child's well-being and enable the child to fulfil his or her rights. In deciding what is in a child's best interests, their own wishes, the level of risk to the child, the resilience factors to mitigate the risk, as well as the family circumstances, should be taken into account. The Child Care and Protection Act, No. 3 of 2015 (Article 3) states that in all matters affecting a child or children in general, the best interests of the child concerned is the paramount consideration. *See Job Aid 10: The best interests of the child.*

**CARE PLAN:** an agreed-upon written plan, regularly updated, which defines how the child is to be cared for, including how to meet the child's needs and respond to the child and family's difficulties.

**CASE MANAGEMENT:** the process of providing protection and support to individual children and their families who are vulnerable to certain risks, directly or through referral services, and following that process through until goals are met. *(Child Protection Working Group. 2014. Inter-Agency Guidelines for Case Management and Child Protection)*

**CASE MANAGER OR CASE WORKER:** usually a social worker; the person who is responsible for ensuring that decisions are taken in best interests of the child, that the case is managed in accordance with the established process, and who takes responsibility for coordinating the actions of all actors.

**CHILD IN DIFFICULT CIRCUMSTANCES:** a child who is found to be in difficult circumstances as listed in Section 131 (2) of the Child Care and Protection Act may be a child in need of protective services (CCPA).

**CHILD IN NEED OF PROTECTIVE SERVICES:** a child who is in need of services aimed at providing care, protection or both care and protection to safeguard his or her safety, security and well-being, or improving such care, protection or both care and protection (CCPA).

**FAMILY PRESERVATION:** services aimed at keeping families together and the provision of services and programmes intended to support and strengthen families. The purpose of family preservation is to empower families in order to reduce the incidence of the removal of children from families (CCPA).

**FAMILY STRENGTHENING:** a deliberate process of empowering parents with necessary opportunities, skills, support and guidance to raise their children successfully, and thus preserve their families (CCPA).

**HIV-SENSITIVE:** to acknowledge and take action in addressing and removing barriers to accessing HIV services.

**RESILIENCE:** the ability to recover from stresses and shocks, and to stay as strong as, or become stronger than, before.

**STATUTORY SERVICES:** services sanctioned by the court, and which obligate social workers to act.

**WELL-BEING:** a positive state of mind and body, feeling safe and able to cope, with a sense of connection to people, communities and the wider environment. Children's well-being considers all aspects of their lives, including their own perceptions of their happiness.

## Introduction

The purpose of this manual is to provide guidance on all aspects of social work case management practice for social workers employed by the Ministry of Gender Equality and Child Welfare (MGECW). The manual contains all the information needed for a social worker to carry out his or her case management tasks. It includes an overview of the policies, strategies and principles that inform case management; the functions required of a social worker and operational guidance; and documentation tools. It is accompanied by job aids to support case management, including tools for documentation and supportive supervision. These documents aim to support the MGECW social workers, but could be useful to all social workers in practise.

This manual is complemented with Child Care and Protection Forum Guidelines, which are both aligned with the Child Care and Protection Act, the UN Convention on the Rights of the Child (UNCRC) and the African Charter on the Rights and Welfare of the Child (ACRWC).

The manual is also accompanied by a training curriculum.

The manual and training curriculum are informed by best practice in the region and globally and extensive consultation with the MGECW, other Ministries and civil society. It was further informed and updated with the learning gleaned from pilots in Kavango East, Kavango West and Khomas.

**Case management** is the process of providing protection and support to individual children and their families who are vulnerable to certain risks, directly or through referral services, and following that process through until goals are met<sup>1</sup>. It is applied for children who face severe risks, for which a family or the community around the family cannot provide protective care and support without assistance.

This document focuses on strengthening the MGECW Child Welfare Directorate's case management through an **integrated case management** lens. The case management process requires that the many different actors providing protective care and support communicate and work effectively together, using a standard set of processes and procedures, within harmonised legal and policy frameworks. An integrated case management approach means that children and families receive a holistic package of care and support, case management skills are shared across the whole social welfare and health workforce, programmes and services to support the child and family are harmonised, and data on outcomes for children and families are shared across different sectors.

Case management for children in need of protective services is headed by the Ministry of Gender Equality and Child Welfare, but requires shared commitment from all government service providers, especially health, education, police and justice. Integration must take place across relevant sectors, at all levels of government and with communities and families; *see Job Aid 6: Basics of integrated case management*.

The role of actors in the community is also central to case management, including neighbours, community members and leaders helping families who are under pressure, communities and religious groups reducing a family's social isolation and stigma, and civil society groups providing a range of social and economic supports to augment state services of health, education, justice and social protection.

Case management is essential in prevention of HIV and support to children and families living with and affected by HIV, and includes a focus on how to increase linkages with HIV services, among others, to ensure MGECW social

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<sup>1</sup> Adapted from Child Protection Working Group. *Inter-Agency Guidelines for Case Management and Child Protection, 2014*.

workers have the ability to support the complex cases of children affected by HIV<sup>2</sup>; **see Job Aid 7: Case management and children living with and affected by HIV.**

This manual includes the following sections:

- **PART 1:** This section sets out the context for the importance of case management for protecting children in Namibia, with information about what case management is and how it is applied in Namibia and within the MGECW, and a summary of the case management elements within the Child Care and Protection Act, No. 3 of 2015, and other relevant Acts.
- **PART 2:** Standard operating procedures (SOPs) for case management of children in need of protective care and other vulnerable clients, with an overview of the overall process followed by a summary of the key steps, including case management forms and accompanying guidance for completing the forms.
- **PART 3:** Job aids to assist in effectively implementing the case management process in Namibia, providing more detail and/or additional guidance in the priority approaches.

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<sup>2</sup> For more information, see World Vision, UNICEF. *Protection and resilience: A simple checklist for why, where and how, to coordinate HIV and child protection policy and programming*, August 2016. <http://ovcsupport.org/resource/protection-and-resilience-a-simple-checklist-for-why-where-and-how-to-coordinate-hiv-and-child-protection-policy-and-programming/>



**PART 1 OF 3:**

Background information on case management for children in need of protective services in Namibia

# 1 | Background to case management

## A. COMMITMENTS OF THE REPUBLIC OF NAMIBIA TOWARDS CHILDREN

Children’s rights to care and protection in Namibia are set out at the highest level. Article 15 of the Constitution, adopted in 1990 and amended in 1998, sets out children’s rights, noting that all children in Namibia have the right to a name, nationality and right to know and be cared for by their parents, other than when it has been legally decided that this is not in their best interests. The family is defined in Article 14 of the Constitution as the fundamental unit of society.

Namibia has adopted the UN Convention on the Rights of the Child and the African Charter on the Rights and Welfare of the Child. The adoption of these global conventions and charters means that Namibia has committed to upholding internationally defined standards of rights for children.

All of Namibia’s policies and actions fall under Vision 2030, which was adopted in 2004. Vision 2030 sets out the broad development goals for the country, and in line with the constitution, upholds the family as the most fundamental institution in the society, and requires that parents (mothers, fathers, guardians, caregivers) are well aware of and fulfil their responsibilities to their children. The Vision commits to gender-equitable policies that combat violence and stigma.

The over-arching national strategy, to which all other plans must relate, is the National Development Plan (currently NDP5). An additional flagship, national plan was introduced in 2016 by President Hage Geingob, titled the Harambee Prosperity Plan, aimed primarily at tackling poverty eradication. Each Ministry has been asked to play its part in realising this plan.

Namibia has a National Agenda for Children (NAC) which brings together the many laws, policies and commitments into one concrete set of priorities. One commitment of the NAC 2012-2016 is to “Strengthen integrated child protection, prevention and response services, such as, gender-based violence (GBV) Units (previously called Women and Child Protection Units - WACPUs), shelters and specialised services at police station level, through development and implementation of standard operating procedures and MoUs with partners for effective referrals” (Priority strategy 5.2.1). Case management is a practical way to ensure that referrals are made, and that actions are followed through to the ultimate benefit of children and their families.

The Child Care and Protection Act, No. 3 of 2015 (CCPA), translates these global commitments into law and commits to a holistic approach to protecting children. See **Section 1.2** below for more detail on the CCPA and key policies that relate to case management.

The government has committed to the protection and care of children by ensuring that there is one lead agency for all activities devoted to children – the Ministry of Gender Equality and Child Welfare (MGECW). The MGECW is the custodian of all policies for children, but there are also many other government ministries and vibrant civil society organisations that are actively engaged with ensuring that children are protected and cared for. A system of Child Care and Protection Forums (CCPF) is delivered by the Ministry to provide a platform for local collaboration and for identification of vulnerable children, and, where necessary, referral into the protection system. Guidelines for the functioning of Child Care and Protection Forums harmonise with this document and should be read in conjunction with it.

The case management procedures outlined in this set of Standard Operating Procedures (SOPs) are built on these national commitments and seek to harness the vitality and richness of the many different actors who provide protection and care for the most vulnerable children.

## B. INTRODUCTION TO CASE MANAGEMENT

Case management is a process for providing protection and support to individual clients and their families, who are vulnerable to certain risks, directly or through referral services, and following that process through until goals are met<sup>3</sup>.

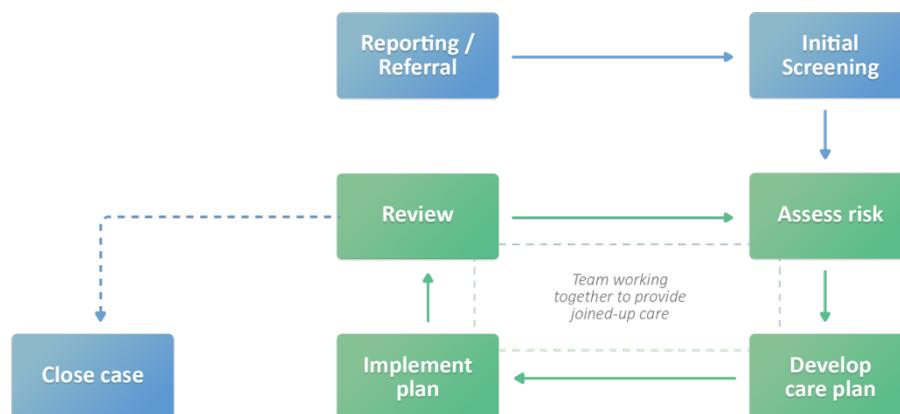
The case management process:

- *identifies* what the type and level of risk may be;
- *assesses* risks and strengths of child and family;
- *sets goals* to mitigate the risk;
- *plans and delivers* actions to address the risk;
- *follows up and monitors* how well the individual client and family are changing, adapting and flourishing due to the interventions and support provided;
- *closes* the case once the goals have been met.

### KEY ELEMENTS OF CASE MANAGEMENT<sup>4</sup>

Case management:

- 1 | Should focus on the needs of an individual child and his/her family, ensuring that concerns are addressed systematically (following agreed procedures and practice) in consideration of the best interests of the child, and building upon the child's and family's natural resilience (strength and assets that make it possible to resist and respond well to adversity).
- 2 | Should be provided in accordance with the established case management process with each case through a series of steps, and involve children's meaningful participation and family empowerment throughout.
- 3 | Involves the coordination of services and supports within an interlinked or referral system.
- 4 | Requires systems for ensuring the accountability of case management agencies.
- 5 | Is provided by one key worker (referred to as a caseworker or case manager), who is responsible for ensuring that decisions are taken in best interests of the child, the case is managed in accordance with the established process, and that someone taking responsibility for coordinating the actions of all actors.



<sup>3</sup> Adapted from *Inter-Agency Guidelines for Case Management and Child Protection* (Child Protection Working Group, 2014).

<sup>4</sup> Child Protection Working Group. *Inter-Agency Guidelines for Case Management and Child Protection*, 2014.

## GUIDING PRINCIPLES OF CASE MANAGEMENT<sup>5</sup>

The following principles reflect good practice in all work with children and vulnerable families. All actors involved in case management should adhere to these principles.

- **Do no harm:** Making sure that, by protecting a child from one risk, the child is not exposed to other risks, for example, not exposing the child to harm when gathering information about the case.
- **Prioritise the best interests of the child:** Assessing the child's and family's strengths and risks, in home and environment, taking short- and longer-term benefits and risks into account when making decisions and taking actions. *See Job Aid 4: Strengths- and resilience-based approaches.*
- **Seek informed consent and/or informed assent:** In all circumstances, consent should be sought from children and their families or caregivers prior to providing services. Informed consent is the voluntary agreement of an individual who understands the issue at hand and has the capacity to give consent, and who exercises free and informed choice. Informed assent is used when a child is too young to give informed consent, but is old enough to understand and agree to participate in services. Assent in this case may be verbal. *See Job Aid 8: Gaining informed consent and assent.*
- **Non-discrimination:** Children must not be treated poorly or denied services because of their sex, age, race, religion, ethnicity, disability or sexual orientation. Case workers should challenge discrimination when they face it.
- **Empower children and families to build upon their strengths:** Children and families have many resources and skills, and can contribute positively towards finding solutions to their own problems. *See Job Aid 4: Strengths-based approaches to case management.*
- **Facilitate meaningful participation of children:** The CCPA states that children have a right to express opinions about their experiences, and to participate in decisions that affect their lives. They have a right to be made aware of their rights to participate or to not participate, to be protected from victimisation when they do participate, and to complain if their right to participate is not respected. There must be active efforts to ensure the participation of children facing barriers for reasons including disability, language or other forms of discrimination. *See Job Aid 5: Promoting child and family participation, and Job Aid 12: Child development as it relates to child protection.*
- **Coordinate and collaborate:** Case management requires the involvement of all actors with a mandate to protect children, including community leaders, government ministries and civil society. The process depends on close collaboration and mutual accountability from all actors, especially ensuring that government and non-governmental organisations (NGOs) take responsibility and account for referrals made between them to avoid duplication. Management and supervision of such shared cases are essential to ensure adequate follow-up.
- **Adhere to ethical standards:** All people who work with children must adhere to professional ethical standards and child protection policies, where these apply, and to cultural and social norms that treat children in a respectful, non-discriminatory way.
- **Respect confidentiality:** Sensitive information should only be shared with those individuals who need to know the information in order to protect the child, and only with a client's permission. This must be clearly explained to children and parents, guardians or caregivers.
- **Ensure accountability:** Everyone involved in protecting children must be held responsible for their actions, and ultimately be accountable to the child, family and community. This means complying with national laws, professional codes of conduct and these guiding principles. Children and families should have routine opportunities to provide feedback on the support they receive.

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<sup>5</sup> Child Protection Working Group. *Inter-Agency Guidelines for Case Management and Child Protection*, 2014.

- **Provide culturally appropriate processes and services:** Caseworkers should recognise and respect diversity in the communities where they work, and be aware of individual, family, group and community differences, except when the best interest of the child conflicts with cultural values or practices, in which case the child's best interests are the priority.
- **Maintain professional boundaries and adhere to child protection codes of conduct:** All child protection actors must adhere to their code of conduct and professional standards, including not asking for or accepting favours or payments in exchange for services or support. Where a case worker has an existing relationship with the child, family or perpetrator, for example, if the social worker is part of the extended family, the case work should notify his or her supervisor, or a senior social worker in MGECW, to assess whether it is appropriate to refer this case to someone else and/or to set and maintain clear boundaries.
- **Use standardized forms and processes:** All child protection actors must use standardized forms and processes to guide their practice to maximize efficiency and ability to offer quality care services.
- **Demonstrate HIV competence and sensitivity:** Namibia has an HIV prevalence of 13.3% amongst 15-to-49-year-olds<sup>6</sup>. Recognising that being infected with or affected by HIV is a common factor in vulnerability and risk for children and their families in Namibia; it is important that MGECW social workers have the knowledge to identify, assess and appropriately refer HIV-related cases. Furthermore, MGECW should have the competencies to assist in complex cases, for example, disclosure of HIV status to children, ARV adherence amongst adolescents, psychosocial support and counselling for affected children and families. *See Job Aid 7: Case management and children living with and affected by HIV.*

#### KEY ACTORS IN CASE MANAGEMENT IN NAMIBIA

The primary purpose of the case management system is to enable the Ministry to comply with the Child Care and Protection Act, for which it is responsible. However, with the addition of some specialised forms, the documentation can also be used for cases of gender-based violence and children in conflict with the law. The intention, over time, is to enable all services provided by the Ministry to be documented under this case management umbrella. Ultimately it is anticipated that these documentation tools could be used by **all actors responsible for children who are in need of protective services**, as outlined in the Child Care and Protection Act.

The procedures outlined here complement the referral system that has already been developed by government and civil society. *See Job Aid 1: Namibia's National Protection Referral Flowchart.*

There are different roles in case management and all are important:

- **Individuals at community level** who identify children who may be at risk of harm and report concerns to local authorities, including to teachers, religious leaders, local chiefs, community health workers or police – their role is to raise concerns and to act as constant eyes and ears for protecting children;
- *Skilled case workers at community level* – volunteers and paid workers with training in a range of different areas of support, and who provide ongoing support to meet the child's and family's needs;
- **Professionals from government and civil society** – others who have specialist expertise that can meet and be held accountable for the different well-being and development needs of children and their families. These actors will make and receive referrals, and take part in child care and protection forums, case conferencing and the integrated response required to support children and their families. These professionals may include police, health workers, HIV carers, teachers (especially life skills teachers and teacher/counsellors) and ECD workers, counsellors, etc. In the case of any professional whose work requires contact with children and who is told of or notices a possible risk, such as police or teachers, reporting is mandatory under the CCPA.

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<sup>6</sup> UNAIDS: Namibia Country Fact Sheet (2015): <http://www.unaids.org/en/regionscountries/countries/namibia>

- **Children’s Advocate**, at the office of the Ombudsman, who receives complaints from the public on child-related issues;
- **Children’s commissioners**, who are magistrates in district courts dealing with all cases of children in need of protective services<sup>7</sup>;
- **Case manager** coordinating all of these different elements of support, referrals and guiding the child and family along the case management process, ensuring that their voices are heard, they receive the services they need and that the situation is improving;
- **Supervisors and managers**, who support the delivery of quality work, including effective case management, and who ensure that all the different parts of the case management system are working together. They are responsible for assisting social workers in decision-making, providing coaching and making appropriate referrals.
- **The Permanent Task Force (PTF)**, whose role is to ensure integrated and coordinated action by key ministries and civil society organisations. The PTF was established to coordinate the implementation of the National Orphan and Vulnerable Children (OVC) Policy and, subsequently, the National Agenda for Children and is the effective platform to ensure an integrated response of all actors who have a mandate to meet the needs and realise the rights of vulnerable children and families which case management requires.
- The coordination of case management at regional and constituency levels falls under the sub-national coordination mechanisms overseen by the MGECW and the PTF. **Child Care and Protection Forums** are the suggested coordination framework for vulnerable children and the Child Care and Protection Forum Guidelines provide further guidance on their role in the coordination of case management.

## **SOCIAL WORKER ROLE IN CASE MANAGEMENT**

Case management usually requires one person to be responsible for making sure that the process is followed through from beginning to end. A case manager will work as a team with child, family, other service providers and community members to deliver the plan.

For children in need of care and protection, the case manager is usually a registered social worker. According to the Child Care and Protection Act, No. 3 of 2015, children in need of care and protection and children in contact with the law must have the support of a designated social worker<sup>8</sup>.

The **CCPA (Section 1)** states that a “*designated social worker*” is a social worker in the employment of the State or a social worker in private practice or in the employment of a child protection organisation that has been designated by the Minister and been certified to carry out the duties set out in the Act. A social worker in private practice or in the employ of a child protection organisation must renew their certificates every two years.

A social worker is the first point of contact for someone who reports a concern about a child. The social worker receiving the report must screen the child to determine whether the child is in need of protective services (and gather evidence as appropriate). **See Job Aid 2: CCPA reporting requirements.**

Social workers may be based within MGECW or MOHSS, within civil society organisations such as LifeLine/ChildLine or others, or may be working privately. These are complemented by other social welfare service providers within

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<sup>7</sup> CCPA Article 38 (4) states that every magistrate appointed for a district is a children’s commissioner for that district, when effecting child protection cases in court.

<sup>8</sup> CCPA regulations will set out the process for according the status of designated social workers. At present, references to social workers in this SOP apply to MGECW-employed social workers.

government. The division of responsibilities amongst such social welfare providers is set out in a “matrix” for social welfare services rendered by MOHSS, MGECW, and the Veterans and Youth ministries.

**The Ministry of Gender Equality and Child Welfare is responsible for making sure that all children in Namibia have the care and protection they need to grow and flourish. Social workers employed by the MGECW carry this responsibility.**

If the child and family need ongoing protective care, the social worker will usually lead the development of a plan and its ongoing review. Others involved include the child and family; service providers who may be able to provide support, such as health, education, social protection and legal services; traditional and religious leaders; and the community at large.

The social worker has a mandate to ensure that all case management decisions are in the best interests of the child. ***See Job Aid 10: The best interests of the child.***

## THE ROLE OF SOCIAL WORKERS IN HIV MANAGEMENT<sup>9</sup>

MOHSS and their civil society partners are the primary role players in care and support of children and adolescents living with HIV.

However, in the context of high HIV burden in Namibia, MGECW social workers are well placed to play supportive roles in identifying, referring and supporting children affected by HIV or at particular risk of HIV infection, as well as their families. After training on HIV and HIV referral and disclosure processes of the Ministry of Health and Social Services, MGECW social workers should be equipped to:

- Through case work, identify HIV-affected and infected children and their families who are in need of services.
- Offer counselling and information, and assist with correct referral into/back into MOHSS care and support services, including HIV disclosure.
- Support children and their families referred by MOHSS for whom longer term counselling is required and where other risks are identified by health care professionals. ***See Job Aid 7: Case management for children affected by HIV.***

## SUPPORT AND SUPERVISION

***See also Appendix: Supportive Supervision Manual***

Social work supervision is well established as an important component of professional social work practice. It is important for increasing the professionalization of social work and improving the quality of social work practice, and has been shown to significantly improve decision-making about children and families.

**Supervision** is a process whereby the supervisor performs educational, supportive and administrative functions in order to promote efficient and professional rendering of services. A supervisor is delegated the authority, and hence the responsibility, to promote ongoing learning and improve performance of the people that he or she supervises. The supervisor is responsible for providing direction to the supervisee, who is, in turn, responsible for applying social work theory, knowledge, skills, competency and ethics in the practice setting.

The educative role is designed to improve self-awareness and increase the social worker’s knowledge base and decision-making abilities. It also improves knowledge of available resources and ways to make appropriate referrals. The supportive function of supervision includes elements of emotional support and encouragement, while

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<sup>9</sup> 2012 USAID PEPFAR guidance states that PEPFAR programs ‘should also partner with governments to support AIDS-sensitive social welfare and child protection policies and programs that benefit all highly vulnerable children’.

administrative oversight safeguards consistency between philosophies, policies and procedures and the actual work being performed (Davis, 2010; Shulman, 1993).

Supervision protects clients, supports practitioners, and ensures that professional standards and quality services are delivered by competent social workers. Supervision provides guidance and enhances the quality of work for both the supervisor and the supervisee and, ultimately, the client.

Some supportive supervision models that may be helpful, specifically in resource-constrained organisations:

- 1 | **Coaching and mentoring** are supervision models that involve problem-solving techniques for better client case outcomes (coaching), and help the case manager to feel more competent and motivated (mentoring) to increase performance as a case manager. In the long run, both processes help the case manager feel supported, valued and moving towards greater achievements.
- 2 | **Peer supervision** is different from traditional forms of supervision in which a qualified 'expert' manages the process and provides supervisory feedback. In contrast, peer supervision refers to a reciprocal arrangement in which peers work together for mutual benefit, emphasizing self-directed learning within the context of support and sharing.

## 2 | Child Care and Protection Act, No. 3 of 2015, and other relevant Acts

The main function of case management for MGE CW social workers is to implement the Child Care and Protection Act, No. 3 of 2015. This is the overarching legal framework for all issues affecting children's care and protection. The CCPA sets out commitments, defines which children are in need of special protection measures, and sets out the system, mechanisms and actors required to implement these measures.

The CCPA gives effect to the Namibian judicial system to protect children. The CCPA has as its foundation the preservation and strengthening of families. Prevention and early intervention is central for managing children's issues.

### PREVENTION AND EARLY INTERVENTION

According to the CCPA, prevention and early intervention programmes may include one or more of the following components:

- A. assisting families to obtain the basic necessities of life, including assisting with accessing grants or empowering them to obtain basic necessities of life for themselves and their children;
- B. providing families with information to enable them to access services;
- C. providing families with information about the dangers of alcohol and other drugs, and assisting them to address abuse of alcohol or drugs by any family member;
- D. providing families with information about gambling addiction, and assisting them to address such addiction of any family member;
- E. supporting and assisting families with a chronically ill or terminally ill family member;
- F. assisting families to provide or access appropriate early childhood development opportunities for children who have not attained the school starting age;
- G. addressing specific issues affecting or potentially affecting families in the community, such as gender-based violence, health and nutrition issues, reproductive and sexual health issues, child labour, child trafficking or child behaviour problems;
- H. providing families with information regarding the resolution of disputes at a family meeting;
- I. promoting the well-being of children and the realisation of their full potential.

Prevention and early intervention programmes must focus on preserving a child's family structure, and strengthen and build capacity and self-reliance, promote appropriate relationships in families, prevent failures in the family environment to meet children's needs, prevent the recurrence of problems in the family environment, and avoid the removal of children from the family environment.

The CCPA makes provision for kinship care to ensure that a child stays within the family environment.

## A. ACTIONS REQUIRED WHEN A CHILD NEEDS PROTECTION FROM HARM

The CCPA recognises that **children must be protected from all types of harm**. The circumstances, set out in Section 131, are listed in **Job Aid 2: CCPA reporting requirements**. The CCPA articulates the **child protection system and response that the duty bearers must put in place** in order to protect a child:

Children living in **alternative care**, whether community-based (foster care and kinship care) or residential care (places of safety, residential childcare facilities; shelters for street children; homes for children with special needs; institutions for children in conflict with the law), have their rights set out in the CCPA, and the court and social workers have a role in ensuring that these rights are protected and children's well-being is monitored.

The CCPA allows for a range of services and programmes to be developed that will improve the situation of children in the country. Furthermore, the Act sets out mechanisms that will improve service delivery and for measurement of services provided. The CCPA sees prevention and early intervention for children in need of care and protection as a core part of the actions to protect children from harm.

## B. CASE MANAGEMENT

The CCPA (**Chapter 10**) identifies the process (normally referred to as a **statutory case management process**) that **must be followed** when a child is found to be in need of care and protection by a social worker. The CCPA makes the provision for:

- **mandatory reporting;**
- **conducting an initial assessment;**
- **measuring risk** – one of the duties and obligations of a designated social worker is to measure the level of risk to which a child is exposed;
- **investigating the circumstances, developing a report, and ensuring a care plan is in place;**
- **bringing the child before a children's court for a protection order** to be affected;
- **supervising the child** with the implementation of a care plan;
- **undertaking family reunification** services or reconstruction services in order to preserve the family.

The CCPA makes provision that specific statutory services must be delivered by 'designated' social workers therefore according these social workers special authority to protect children from further harm or danger.

*Note:* Currently, regulations for the CCPA are being drafted. Once regulations are finalised, the steps will be further refined. Processes that are proposed in the Act, but without accompanying regulations, follow a combination of global good practice and input from MGECSW social workers based on local practice.

## C. OTHER LEGAL AND POLICY TOOLS FOR CASE MANAGEMENT

The CCPA is the overriding law for children in need of protective services. There are a number of other laws that provide protection to children:

- **Criminal Procedure Act, No. 51 of 1977**, sets out the processes for all criminal procedures, including children in conflict with the law and child witnesses. Currently, juvenile justice procedures are in line with this Act, pending finalisation and enactment of the proposed Child Justice Bill.
- **Births, Marriages and Deaths Registration Act, No. 81 of 1963**, allows for all children born in Namibia to have a birth certificate. This Act is currently under review.
- **Combating of Rape Act, No. 8 of 2000**, states that all coercive sexual acts committed against either males or females are a crime. The Act classes any sexual act committed with a boy or a girl under the age of 14 by someone who is more than three years older as coercion. The Act has stiff sentences for those found guilty of rape of young children. The Act distinguishes between adult perpetrators and those under the age of 18, whose age must be taken into consideration, but will still be able to be tried for rape. The law protects victims by not permitting questioning of their sexual history.
- **Combating of Domestic Violence Act of 2003** states that anyone experiencing domestic violence (physical, sexual, economic, emotional or verbal abuse, intimidation and harassment) can apply for a protection order, and the perpetrator can be charged.
- **Combating of Immoral Practices Amendment Act, No. 7 of 2000**, makes it a criminal matter for any person to commit or attempt to commit (for example, by making them drink alcohol with the intention of having sex with them) a sexual act with a child, when the person is more than three years older than the child.
- **Maintenance Act, No. 9 of 2003**, provides a legal basis of monitoring and ascertaining that parents, especially fathers, take full responsibility for all their children. The Act can be applied when a parent or spouse who is able to contribute towards maintenance of the dependent spouse and/or child(ren) has failed to do so voluntarily.
- **Married Person's Equality Act, No. 1 of 1996**, sets the age of civil marriage at 18 years for both men and women.
- **Education Act, No. 16 of 2001**, accompanied by the **Education for All National Plan of Action 2002-2015** and education sector policies on **HIV and AIDS**, on **Orphans and Vulnerable Children** and the **Education Sector Policy for the Prevention and Management of Learner Pregnancy** affirm the role of the education sector in protecting and caring for all children, including children in need of protection and care. This includes prevention of pregnancy, HIV-prevention programming and life skills. Namibian schools have a system of guidance, learning and support counsellors who play an important role in case management. The Education Act is currently being updated.
- **Labour Act, No. 11 of 2007**, sets the minimum age for paid work at 14 years and for hazardous work at 18 years, although hazardous work in agriculture is not defined. Child sexual exploitation and trafficking are addressed in the CCPA.

The Child Justice Bill is not currently enacted, but will set out important steps for children in conflict with the law. There are also policies and strategies that focus on implementation of the law:

- **National Agenda for Children (NAC) 2012-2016** is an integrated strategy for children across all key areas of child well-being and vulnerability, including health, education, HIV, social protection and child protection<sup>10</sup>. The case management process outlined in this manual is a practical way in which the goals and objectives of the NAC can be realised for individual children. The NAC is currently being updated.

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<sup>10</sup> The current NAC expired in 2016, and a new version is in draft. This will be referenced in a later version of this operations guidance.

- **National HIV and AIDS Strategic Framework 2010/11 – 2015/16** aims ‘to maintain and improve the quality of life of Namibia’s people by preventing new infections from occurring and by providing comprehensive and quality treatment, care and support for those already infected by HIV and AIDS’, addressing prevention of new infections, ensuring that people living with HIV live longer and reducing the socio-economic impacts of HIV, especially among vulnerable households. Each region has its own plan, aligned to the National Operational Plan.
- **National Policy for Orphans and Vulnerable Children** sets out the definition of vulnerable children, and is the framework around which many sector-specific actions are set out.
- **Education Sector Policy for Orphans and Vulnerable Children 2008** sets out steps for supporting children who are at risk of dropping out of school, and allows for providing support for children who are in need of protective care and support.
- **National Plan of Action on Gender-based Violence 2012-2016** includes child protection and trafficking concerns.
- **Education for All National Plan of Action (2002-2015)** focuses on providing all children, including the most vulnerable, with relevant and quality education.
- **Decent Work Country Program (2010-2016)** aims to eliminate forced labour and child labour, and sets out priorities for family and young people’s employment and enhanced social protections.

In addition, there is a **Children’s Advocate** within the Office of the Ombudsman who investigates complaints about violations of children’s rights.



**PART 2 OF 3:**

Standard operating procedures  
and guidance for related  
documentation tools

## 1 | Overview of case management process

The case management standard operating procedures and documentation tools in this case management operations manual have been developed for use by the Ministry of Gender Equity and Child Welfare. The primary purpose is to enable the Ministry to comply with the Child Care and Protection Act, for which it is responsible. However, with the addition of some specialised forms, the documentation can also be used for cases of gender-based violence and children in conflict with the law. The intention, over time, is to enable all services provided by the Ministry to be documented under this case management umbrella. Ultimately it is anticipated that these documentation tools could be used **by all actors responsible for children who are in need of protective services**, as outlined in the Child Care and Protection Act.

The standard operating procedures (SOPs) and documentation tools set out in this manual must be used in all cases in which a child is identified as possibly at risk and in need of protection. There are further specific processes and documentation tools that are required once a child is in need of specific protective actions as set out in the CCPA; these include placement outside of family care (foster care and adoption) and children in conflict with the law.

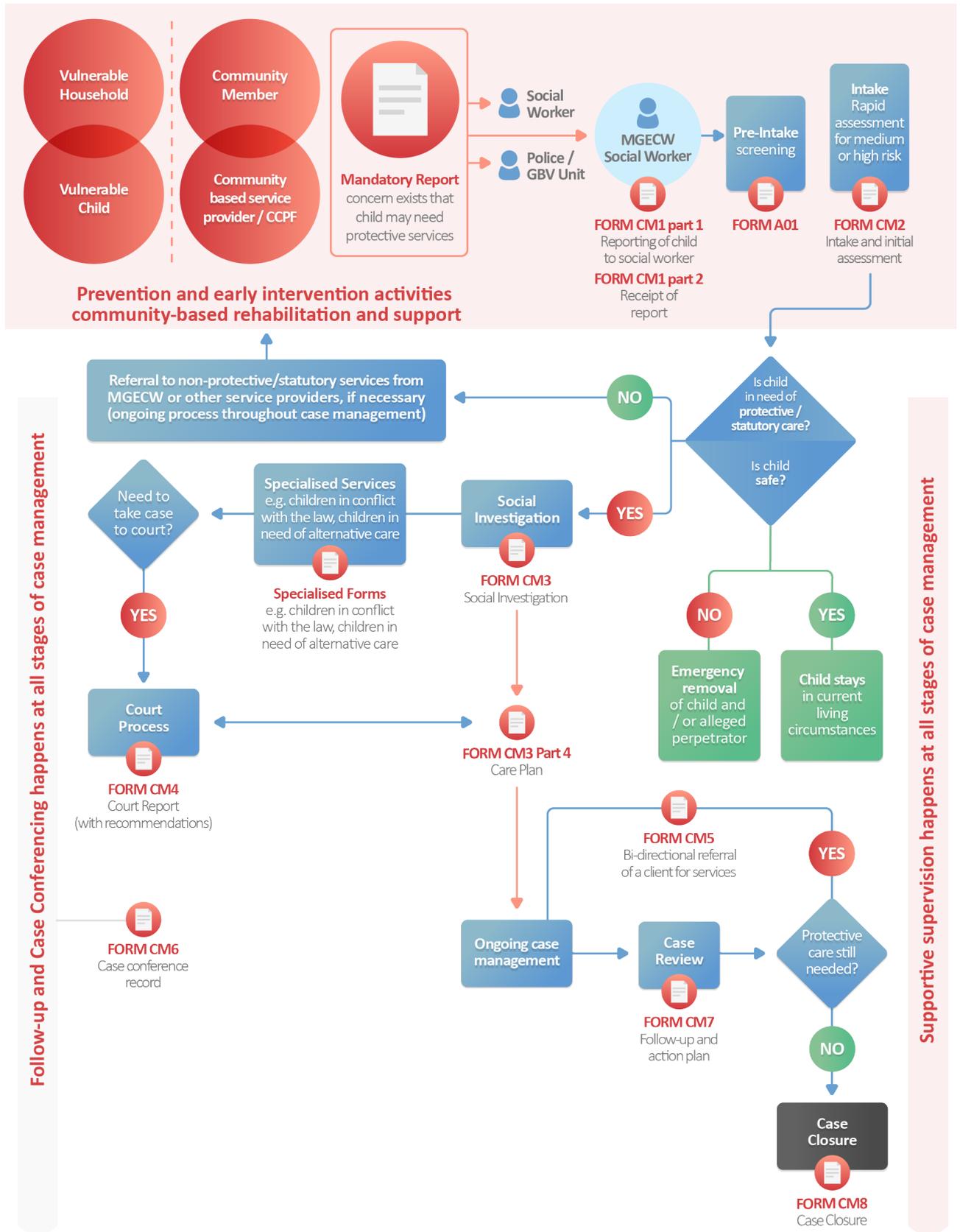
The standard operating procedures in this section set out, step by step, what is needed from initial identification of a child who is possibly at risk of harm and in need of protection and care, through the process of identification, reporting to the MGECW, screening, assessment, planning and delivering an integrated response to the child's multiple needs, and ongoing support through to case closure.

- The process is in line with the requirements of the **Child Care and Protection Act, No. 3 of 2015**, and other laws, notably the Criminal Procedure Act, No. 51 of 1977.
- The process seeks to ensure that there is a **strong link between the proposed case management process for individual children and families and the already existing strong community initiatives** supporting vulnerable children. Community support is usually coordinated through the Child Care and Protection Forums, and delivered by a range of service providers through both government and civil society groups. The case management process should enable children facing risk to be seen and supported on an individual basis, and linked into existing prevention and early intervention programmes at community level. This document is accompanied with the operational case management guidance set forth in the updated Child Care and Protection Forums Guidelines.
- The process relies on case conferencing between different sectors – when one child is receiving multiple sources of support, it is important that all actors work together. The processes shown here focus on the care and protection elements of a child's vulnerability, building on existing assets and strengths. A child receiving care and support case management may well be receiving other support. The specialist case management processes of health or education, for example, are not shown here.

**The Namibian Child Protection Case Management Process is depicted in the chart below, and illustrates the steps that must be followed, from identifying a vulnerable child in the community, to reporting, intake, assessment, development and follow-up on case plan by the MGECW to case closure.** These steps are led by a social worker as lead case manager in all cases concerning a child at risk of harm and/or in need of care and protection. The process includes both statutory and non-statutory actions. Although the social worker is the lead, the process requires ongoing engagement with the child and family at all stages, and with all other key actors who have a role in providing support. The process depends on ongoing review. It includes service provisions and referrals to services so that others can lead on specific areas, for example on health care. Referrals are an important part of case management, ensuring active engagement by all the actors who have a role in supporting the children and their families.

## Namibia Child Protection Case Management Process Chart

This is a summary of the key statutory steps as set out in the CCPA for children in need of protective services and applies to all formal and non-formal actors with a role in protecting children



## 2 | Summary of key steps

Process	Actions	By whom and to whom?	Documentation tools
<b>Step 0:</b> Identification of vulnerable child, family or adult	Identify a child, family or vulnerable adult who may need support.	Child or community member individually or via the CCPF	None
<b>Step 1:</b> Reporting of a client to a social worker	<ol style="list-style-type: none"> <li>Alert to any social worker or police of child in need of statutory protective services. Police or non-MGECW social worker refers immediately to MGECW social worker for investigation.</li> <li>In case of a vulnerable child, family or adult needing non-statutory services, notification to a social worker for investigation.</li> </ol>	<p>Child or community member individually or via the CCPF to social worker or police</p> <p>Reporting is mandatory for all professionals who have a concern about a child's protection/safety.</p>	<p><b>Form CM1, Part 1: Reporting of a client to a social worker.</b> Report made immediately when a concern is identified – written report is mandatory for professionals.</p> <p><b>Form CM1, Part 2: Receipt</b> to complete and return to reporting source, completed by social worker.</p> <p>A verbal report may be made by a non-professional.</p>
<b>Step 2:</b> Screening, intake and initial risk assessment	<ol style="list-style-type: none"> <li>Screening and triaging of clients.</li> <li>Registration of basic details.</li> <li>Rapid risk assessment to enable immediate emergency action if required.</li> <li>Decision on level of risk and appropriate action.</li> </ol>	<p>AO or other designated person screens clients before referring to a social worker.</p> <p>CM2 Part 1: Can be completed by AO, social worker or even the client himself/herself.</p> <p>Social worker completes Form CM2; not forwarded to anyone.</p>	<p><b>Form AO1: Administrative Officer Client Screening</b></p> <p><b>Form CM2:</b> Intake and risk assessment completed without delay, and no later than 48 hours after report is made if forwarding to social worker employed by MGECW.</p> <p><b>Part 1:</b> Demographic profile, needs ongoing updating  <b>Part 2:</b> Presenting problem for any adult or child case  <b>Part 3:</b> Rapid risk assessment for any child at risk, to be completed no later than 48h after report is made  <b>Part 4:</b> Level of risk and next steps  <b>Part 5:</b> Case action  <b>Part 6:</b> Consent for case management  <b>Part 7:</b> Respondent information</p>
<b>Step 3:</b> Social investigation with care plan	<ol style="list-style-type: none"> <li>Social investigation of child deemed to be at medium or high risk.</li> <li>Joint development of care plan with child/ family and other key actors (can be developed while waiting for court hearing).</li> </ol>	Social worker with child, family, all other key actors, including community service providers	<p><b>Form CM3: Social investigation</b>  <b>Part 1:</b> Client and case review  <b>Part 2:</b> Social Investigation  <b>Part 3:</b> Child's Voice/child wellbeing  <b>Part 4:</b> Care Plan</p> <p><b>Form CM3a: Specialised form for children in conflict with the law.</b></p>
<b>Step 4:</b> Court process, where required under CCPA	<ol style="list-style-type: none"> <li>In cases of medium and high risk, court report should be made, when court proceeding is required under CCPA.</li> </ol>	Social worker, with support from Supervisor	<b>Form CM4: Court Report</b> Court report (in some cases), to be ready for court date which must be fixed no more than 30 days after intake if child removed, and no more than 45 days if child remains at home.
<b>Steps 5-7:</b> Referral, follow up & case review	<ol style="list-style-type: none"> <li>Referral to other support</li> <li>Ongoing identification of integrated case management opportunities through case conferencing</li> <li>Follow-up and review of case to assess progress towards goals and if other services required</li> <li>Updating care plan, as needed</li> </ol>	Child, family (where appropriate), social worker and other stakeholders	<p><b>Form CM5: Bidirectional referral of a client for services</b>  <b>Part 1:</b> Referral of a client for services by another service provider  <b>Part 2:</b> Receipt of client referral for services</p> <p><b>Form CM6: Case Conference Record</b></p> <p><b>Form CM7: Follow-up and updated action plan</b></p>
<b>Step 8:</b> Case Closure	<ol style="list-style-type: none"> <li>Case closure, once child considered no longer at risk and support mechanisms are in place and functioning</li> </ol>	Child, family (where appropriate), social worker	<b>Form CM8: Case closure</b>
<b>Throughout:</b> Case tracking	<ol style="list-style-type: none"> <li>Ongoing case review via case tracking and supervision</li> </ol>	Social worker with supervisor	<b>Form CM9: Case-tracking form</b>

### 3 | Case management steps and documentation tools, with guidance

In this section, each step is looked at in detail, outlining the purpose, whether or not it is mandatory in terms of the CCPA and what the outcome is.

The guidance on each form follows, and is in blue.

The forms document the social work process and enable the social worker to collect data, which can be analyzed and referred to for the purposes of decision-making and report writing. It is important that the forms are completed carefully and kept on file for later reference and for justification of decisions made. The forms will also be invaluable to supervisors, enabling them to monitor progress, and to guide and support social workers through the process.

On some of the forms, check boxes are provided as a means of quick, initial recording. However, **these are not sufficient on their own**. A brief written explanation must be provided in the space alongside, justifying the selection.

#### STEP 0: IDENTIFICATION OF VULNERABLE CHILD, FAMILY OR ADULT

##### WHAT IS THE PURPOSE OF THIS STEP?

**Identification** of a vulnerable child, family or adult is made so that the individual[s] can receive further support from statutory or non-statutory services. This step brings a client to the attention of the social worker through mechanisms that the Ministry has developed for this specific purpose and described in the following step. The CCPF forums are one such mechanism. The members of this structure perform a critical role in child protection and normally act as eyes and ears on the ground. Any member of such a structure has a duty to report to their nearest social worker or to the police. Any member of the public is encouraged to report to a CCPF member or to a social worker or to the police directly. Such reports are normally verbal.

#### STEP 1: REPORTING OF A CLIENT TO A SOCIAL WORKER

- Whilst this step is contained in the provisions of the CCPA, it is not a function of a social worker that works within the MGECW.
- Inclusion of the step in the CCPA is aimed at making professionals, community and other service providers part of the protection network and therefore gives the responsibility to all for child protection: 'Child protection is everyone's business'.
- The information below is aimed particularly at professionals who, in the scope of their work, come across a child who is at risk of harm, neglect or exploitation. It can also apply for community-based service providers and the community at large.
- MGECW, as the custodian of the Act, is mandated to create awareness of the responsibility of reporting, and to create a system for disseminating the information, as well as reporting forms to all health and education facilities, professionals in private practice, NGOs and any other appropriate setting in which professionals can make a report to MGECW.

##### WHAT IS THE PURPOSE OF THIS STEP?

*Following the identification of risk and/or vulnerability, this step provides for...*

- **Formal reporting of a concern about a child at risk of harm** by anyone in the community, child or adult.
- **Reporting a concern about a child, family or vulnerable adult** who may require non-statutory social welfare services.

## IS THIS MANDATORY?

Any adult or child in the community who suspects that a child requires protective services **MUST report** verbally their concern to a social worker or police officer. Any professional, working in government or civil society, **MUST report** in writing, and is encouraged to use **Form CM1: Reporting of a client to a social worker**.

Any adult or child who thinks that a child, family or adult is vulnerable and needs non-statutory support **MAY inform** someone in the community who can provide help, or complete preliminary identification for action and referral through the CCPF or other local coordination mechanism. In this case, a verbal report is sufficient, but Form CM 1 may also be used.

## WHAT IS THE OUTCOME?

A social worker employed by MGECW is alerted to a potential case requiring statutory or non-statutory services, and can begin an assessment. Other community actors can be brought in at any point to provide other forms of support, including prevention and early intervention support.

### GUIDANCE FOR COMPLETING FORM CM1: REPORTING OF A CLIENT TO A SOCIAL WORKER

This form should **not** be completed by a MGECW social worker. It is intended for reporting from outside, and is sometimes called a referral-in form. The role of the social worker is to make all stakeholders aware of the reporting form and request their cooperation in the use of the CM1. In addition, the social workers should ensure that all entry points where children can be and are reported from have copies of the reporting form. The form should include the following information:

1. *The date of the report and the name and other details of the person making the report, so that follow-up can be done when needed, and feedback provided.*
2. *As much detail as possible about the client's contact information, so the client can be contacted and/or followed up.*
3. *If the client is a child, name and contact details of child's parent, guardian or caregiver, with enough detail to contact them for follow-up. (There is a space to note any special circumstances that the child is in, such as child-headed household or other form of residential care, etc.) For all clients, collect details of next of kin.*
4. *The "Presenting problem" section should be brief, but contain the essential information about why a report is being made: specific incident if occurred, and nature of incident. If emergency action is required, that should be noted in this section.*
5. *If the information comes from someone mandated to take action, e.g., police or health worker, this should be immediately verified with the person making the report. When information is not clear, immediate follow-up with direct contact should be undertaken to verify if emergency action is required.*
6. *The person making the report should sign on the bottom of page 1.*
7. *Communication with client and relevant parties: if not completed on the form, the social worker should verify with the person making the report. If consent has not been sought, the social worker should follow up immediately.*
8. *Additional information should be supplied on page 2, where available and relevant.*
9. *Any documents supplied with the report should be noted.*
10. *On receipt of the form, the social worker completes the shaded section at the bottom of page 2.*

**TAKE EMERGENCY ACTION TO PROTECT THE CHILD BEFORE COMPLETING THE FORMS IN ANY DETAIL.** However, it is important to document the reasons for taking the action as soon as possible using **Form CM2**.



Ministry of Gender Equality and Child Welfare

## CM 1: Reporting of a client to a social worker | Part 1

Please complete page 1 for any child or adult needing mandatory or non-mandatory social services

<b>Particulars of the person making the report / referral</b>		Date of reporting: DD / MM / YYYY	
Type of services needed: <input type="checkbox"/> Protective services <input type="checkbox"/> Other social welfare services		Reporter: <input type="checkbox"/> Self-referral <input type="checkbox"/> Family/Friend <input type="checkbox"/> Professional <input type="checkbox"/> Other:	<input type="checkbox"/> Verbal report
Name of person making report:		Organization / Practice # (if applicable):	
Contact information:			
<b>Client information</b>		CR case number (if applicable):	
Client's surname:		First name(s):	
Date of birth: DD / MM / YYYY	Age:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Home language:
Address/ERF no/location/village/constituency:		Citizenship: <input type="checkbox"/> Namibian <input type="checkbox"/> Unknown <input type="checkbox"/> Other:	
Cell:	Other tel:	More than one child concerned: <input type="checkbox"/> Yes (If yes, how many? ) <input type="checkbox"/> No	
Next of kin name: Relationship to client: Cell: Address: <input type="checkbox"/> Same as above <input type="checkbox"/> Different (write below):		Best way to reach client or family:  (Note: If best way is at school, note school name and grade):  Child-headed household: <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Presenting / reported problem / case type</b> (Check all boxes that apply; circle subcategory where relevant)			
<input type="checkbox"/> Abuse (physical / emotional) <input type="checkbox"/> Abuse (sexual / rape / incest) <input type="checkbox"/> In need of care or protection (neglect / abandonment / orphans / baby abandonment) <input type="checkbox"/> Child living and working on the street <input type="checkbox"/> Domestic violence <input type="checkbox"/> Child abduction / kidnapping <input type="checkbox"/> Child trafficking <input type="checkbox"/> International social services <input type="checkbox"/> Foster care / adoption <input type="checkbox"/> Custody and guardianship (custody and access / custody and control / guardianship) <input type="checkbox"/> Children's home <input type="checkbox"/> Child maintenance		<input type="checkbox"/> Child exploitation (child labour / early child marriage / sexual exploitation) <input type="checkbox"/> Child in conflict with the law <input type="checkbox"/> Behavioural problems (alcohol / drug abuse / other: ) <input type="checkbox"/> Beneficiaries Claims: GIPF / other: <input type="checkbox"/> Health (HIV infected / affected) See job aid 7 <input type="checkbox"/> Health and nutrition issues: <input type="checkbox"/> Disabilities (physical / mental / psychological) <input type="checkbox"/> Teenage pregnancy / young mothers <input type="checkbox"/> Psychosocial distress (bereavement / trauma) <input type="checkbox"/> Pre-sentence request / report <input type="checkbox"/> Child witness support services <input type="checkbox"/> Other:	
Reason for reporting: please explain in detail here		Is emergency action required? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Police <input type="checkbox"/> Emergency medical services <input type="checkbox"/> Placement of safety / removal <input type="checkbox"/> Other: Please explain:	
Signature of person making report:		Date DD / MM / YYYY	



## Additional information as appropriate

<b>Case communication:</b>				
• Does the client know that this report has been made?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
• If a child, does parent/guardian know this report has been made?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
• Does the alleged perpetrator ( <i>if there is one</i> ) know that this report has been made?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Has the client been in contact with MGECW on previous occasions? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know				
If yes, reason:		Date: DD / MM / YYYY		Case number:
Any other support and/or agencies working with client? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, who/connection:				
<b>Additional parties (children / respondent / others) concerned with primary client:</b>				
Surname:	First names:	Relationship:	DOB: DD / MM / YYYY Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Contact info: <input type="checkbox"/> Same as primary client <input type="checkbox"/> Different: Issues / needs: <input type="checkbox"/> Same as primary client <input type="checkbox"/> Different/additional:				
Surname:	First names:	Relationship:	DOB: DD / MM / YYYY Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Contact info: <input type="checkbox"/> Same as primary client <input type="checkbox"/> Different: Issues/needs: <input type="checkbox"/> Same as primary client <input type="checkbox"/> Different/additional:				
Surname:	First names:	Relationship:	DOB: DD / MM / YYYY Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Contact info: <input type="checkbox"/> Same as primary client <input type="checkbox"/> Different: Issues/needs: <input type="checkbox"/> Same as primary client <input type="checkbox"/> Different/additional:				
Surname:	First names:	Relationship:	DOB: DD / MM / YYYY Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Contact info: <input type="checkbox"/> Same as primary client <input type="checkbox"/> Different: Issues/needs: <input type="checkbox"/> Same as primary client <input type="checkbox"/> Different/additional:				
Surname:	First names:	Relationship:	DOB: DD / MM / YYYY Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Contact info: <input type="checkbox"/> Same as primary client <input type="checkbox"/> Different: Issues/needs: <input type="checkbox"/> Same as primary client <input type="checkbox"/> Different/additional:				
Surname:	First names:	Relationship:	DOB: DD / MM / YYYY Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Contact info: <input type="checkbox"/> Same as primary client <input type="checkbox"/> Different: Issues/needs: <input type="checkbox"/> Same as primary client <input type="checkbox"/> Different/additional:				
Other known needs and/or other important/relevant information: Documents accompanying this referral form:				
<input type="checkbox"/> Psychosocial report		<input type="checkbox"/> School report:	<input type="checkbox"/> Medical report	
<input type="checkbox"/> Birth certificate		<input type="checkbox"/> Death certificate	<input type="checkbox"/> Other:	
<b>TO BE COMPLETED BY MGECW ONLY</b>				
Report received by:			Official Stamp:	
Date / time of receipt: DD / MM / YYYY Time: HH:MM				
Date case entered in registry: DD / MM / YYYY				
Case assigned to:				



**CM 1: Reporting of a client to a social worker | Part 2: Receipt for reporting**  
Please complete page 1 for any child or adult needing mandatory or non-mandatory social services

Date: DD / MM / YYYY

Date received: DD / MM / YYYY

Contact details / address of the person reporting or referring client:

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Dear Sir, Madam, Colleague,

I, \_\_\_\_\_ (MGECW social worker name and title) \_\_\_\_\_, hereby acknowledge the receipt of the report /referral on \_\_\_\_\_ (client's name) \_\_\_\_\_, case number \_\_\_\_\_ for follow up services. We thank you for bringing this client to our attention.

**We have reviewed the report / referral information and would like to inform you that the following actions will be undertaken:**

Case is receiving attention and further investigations are being made: \_\_\_\_\_

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MGECW is able to, or has provided requested services: \_\_\_\_\_

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Did not provide requested services because (explain in brief): \_\_\_\_\_

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We value your interest in this client and sincerely appreciate your contribution to improving the lives of others.

Yours Sincerely,

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MGECW Social Worker Name

Signature

Official date stamp

Telephone:

## STEP 2: SCREENING, INTAKE AND RISK ASSESSMENT

### WHAT IS THE PURPOSE OF THIS STEP?

**Screening** can be seen as a customer service process, which ensures clients are welcomed, are in the right place, and are seen in an appropriately prioritised order by the correct person. Other functions of **screening** are: basic data collection, triaging and early identification of additional needs. Even if clients are presenting for a grant only, they often have other stressors/concerns that need to be identified and addressed. Further, as many clients are unaware of support services available, reviewing these options increases client awareness, and will encourage clients to return when/if issues do exist.

The purpose of the **intake** is to collect demographic details of the client and others associated with the case, understand the details of the case, and to make initial decisions on any services to be provided and, where relevant, internal and external referrals to be made.

In the case of a child, this step includes conducting a **rapid risk assessment** in order to ensure the safety of the child. The assessment captures a concise picture of the current status of the child, including his or her home environment, noting the strengths and supportive factors present in the home and possible harm that the child is facing. The assessment determines the **nature and extent of risk** the child may be exposed to in order to make a decision about whether a child is **safe or not safe**. **Where there is immediate risk to life or well-being of the child**, and if the social worker and police officer feel that it is in the best interests of the child to be removed from where he or she is living or to remove the alleged perpetrator, this step includes taking immediate action to ensure the safety of the child through either removal of the child temporarily or removal of the alleged perpetrator (CCPA 134:2). The social worker approaches a children's commissioner for the issue of a warrant; if the case is too urgent to wait for a warrant, the social worker, with police, can immediately remove the child and submit a report to court by the next court day.

**Consent must be provided whenever possible, except when the adults in the home refuse access and there are grounds to believe that the child is at risk of harm.**

### IS THIS MANDATORY?

Initial risk assessment is mandatory within 24 hours of receiving a report on a child who may be in need of protective services.

### WHAT IS THE OUTCOME?

The case is opened and action taken. The end result of the assessment is a **decision about which steps to take and which other service providers may be required**.

In the case of a child identified as facing life-threatening risk or serious harm to their well-being, the child is removed and action can be taken to protect the child immediately and in the long-term.

### SCREENING PROCESS:

Prior to intake, a screening step may be utilised which can be carried out by an administrative officer, or intern if available. This is a customer service or triaging approach to ensure that those in the queue are seen in the correct order, that clients are in the correct place, and that any clients in distress are prioritised. Screening further provides for identification of other needs through use of the screening form AO1, and can also alleviate the data-capturing burden on the social worker by the screener completing CM2 Part 1 (demographic profile). In some cases, clients themselves may be directed by the screener to fill in this section themselves.

### GUIDANCE FOR COMPLETING FORM AO1: ADMINISTRATIVE OFFICER CLIENT SCREENING

- *Screeners should have their own registration book to document every presenting client/call.*
- *Each client, regardless of their stated reason for presenting (e.g., only a grant), should be screened for potential need for additional services. Whenever there are concerns (e.g., a mother smelling of alcohol or a teenage mother), a referral should be made to a social worker for intake and risk assessment.*
- *The AO should also refer any clients appropriately to other agencies/services as needed, documenting the referral in the registration book (using CM5-bi-directional referral form).*



## AO 1: Administrative Officer client screening form

To be completed for anyone coming to MGECW

Date: DD / MM / YYYY

For every client presenting to MGECW, use these questions to screen for issues:

Client's surname:	First name(s):	Date of birth: DD / MM /YYYY
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### Have you been to any MGECW office before?

If yes, where: \_\_\_\_\_ When: \_\_\_\_\_

Who did you see: \_\_\_\_\_ Reason: \_\_\_\_\_

**Our social work team can help to get to know your concerns and assist as they are able.**

**Are there any issues that you or your family need support with?**  Yes  No

<input type="checkbox"/> Child protection services	<input type="checkbox"/> Child support services
<input type="checkbox"/> Abuse: (physical, emotional, sexual, rape)	<input type="checkbox"/> Child maintenance
<input type="checkbox"/> In need of care or protection (neglect / abandonment / orphans)	<input type="checkbox"/> Custody and guardianship (custody and access / custody and control / guardianship)
<input type="checkbox"/> Disabilities	<input type="checkbox"/> Foster care / adoption
<input type="checkbox"/> Concern about alcohol or drug abuse	<input type="checkbox"/> Health and nutrition concerns
<input type="checkbox"/> Child living and working on the street	<input type="checkbox"/> Beneficiaries claims: GIPF / other:
<input type="checkbox"/> Behavioral problems	<input type="checkbox"/> Teenage pregnancy / young mothers
<input type="checkbox"/> Child abduction / kidnapping / trafficking	<input type="checkbox"/> Psychosocial distress /emotional support

Any other concerns:

Any other observations that may be concerning that should have a social worker assessment?  
(e.g. smelling of alcohol, teenage pregnancy / mother under 18):  Yes  No

Referral being made:  Yes  No To Whom: \_\_\_\_\_

Form CM2 part 1: demographic profile completed:  Yes  No To Whom: \_\_\_\_\_

Please remind client: referral does not mean that every problem can be addressed, but they can explore options and may be able to benefit from additional services as needed.

## GUIDANCE FOR COMPLETING FORM CM2: INTAKE AND RISK ASSESSMENT

When completing **Form CM2**, the social worker opens a case. The form supports intake and immediate risk assessment. In the case of a child who may be in need of protective services, CM 2 must be completed in all cases **within 24 hours of receipt of a report**. If a non-MGECW social worker receives the initial report, she or he must undertake a rapid risk assessment and advise a social worker employed by the MGECW within 48 hours. Part 1 may be completed by an administrative officer or another designated person. Part 2 onwards must be completed by a MGECW social worker.

**Form CM2** is completed following **at least one meeting with the client**. In case of an urgent response, the social worker will likely immediately complete the form in order to take action. If there is no immediate risk to the client's life or security, intake and assessment may require several home visits. The social worker will need to identify who else to talk with to gather the essential information.

### GUIDANCE ON SPECIFIC SECTIONS:

#### **PART 1 | CLIENT DEMOGRAPHIC PROFILE**

The Client Demographic Profile is critical, and provides a full overview of the client, her/his family members and any other individuals involved in the case, and should be completed as soon as possible. Previous history with MGECW is also captured to enable tracing of existing files and ongoing case work. This part may be completed by an administrative officer or other person designated by a supervisor or even by the client themselves.

Demographic information obtained through CM1 should be verified. At all subsequent contacts, the information in the demographic profile should be checked and updated where necessary. Space for demographic updates is provided at the bottom of page 1 and can be continued on a blank page, if needed.

Important to note:

- *If more than one child is within the same family/household and faces the same risks, they can be treated as **one family case and one case management process with separate sub-cases for each child**. Each child will need an individual form, with unique identifying number, respective risks, strengths and needs noted, as well as individual progress noted within the following care plan (**Form CM3, Part 4**) and ongoing reviews.*
- *For date of birth and estimated age, view birth certificate if possible. If no birth certificate is available, estimate age. It is not essential to have a birth certificate or identity number at this stage.*
- *The person completing Part 1 must sign at the bottom of page 2 before handing the form on for completion by a social worker.*

#### **PART 2 | PRESENTING PROBLEM.** *To be completed by a social worker.*

Complete the check-box section, noting all case types that apply, as well as the date and location of any incident. This is important for data capture and for any subsequent court report. Use the space provided to note more details on the presenting problem, and for any additional information since the initial report.

Use the labelled page to capture any additional process notes, ecomaps or genograms. Ecomaps are diagrams that show the client in the centre with his/her connections to others (positive and negative) around him/her. Ecomaps can be useful in assessing and planning with clients to identify strengths and resources. Likewise, genograms can be useful to make a map of a client's family (family tree), which can help when discussing family relationships and dynamics and bringing a family's strengths and weaknesses into the open.

Consider the following questions:

- *Have you contacted a supervisor or senior colleague if you require any guidance?*
- *Have you contacted the police if the report may constitute a criminal offence against the client? If so, have all the relevant parties been informed of the report? Have the police and social worker team agreed on how to interview and record?*
- *Has the client been taken to the health facility if medical examination or support is required?*
- *Are there other children or parties in the household who may also be suffering or at risk of suffering significant harm?*
- *Have you seen the client on his or her own to give him or her opportunity to present his or her own views? If so, make sure that notes have been taken at the time to ensure that the client's views are documented. If the client is a child, make efforts to allow the child to express his or her feelings according to age and developmental stage.*
- *Do the parents or caregivers believe the child?*
- *Are there other witnesses who can provide additional information? This can include the person making the referral and others who know the client and family. This may also include a teacher, health extension worker (HEW) or health worker, religious leader, neighbour, CBO groups or others. Have you talked to them and recorded their full name and contact details?*
- *Have there been any previous incidents? If so, note any identifying details, e.g., police case number, name of social worker involved in case, etc.*

### **PART 3 | RAPID RISK ASSESSMENT**

Risk assessment must be used for any clients who are children or in adult/GBV cases that children witnessed, were involved in the case, and/or live with the client.

For cases where no children are involved or are at risk, proceed to Part 4: Case Action.

Use the check boxes on the left to record observations. In each case the space alongside MUST be used to justify or explain the selections, as check boxes alone are not sufficient to inform effective analysis and decision-making.

#### **RAPID RISK ASSESSMENT FAMILY PROFILE AND IMPACT ON CLIENT:**

##### **A. FAMILY BACKGROUND AND COMPOSITION:**

- *This information can be gathered from visits. Be sure to distinguish between family members and those who live in the household.*
- *Note the presence of biological parents and, if not present, note whether they are deceased, not present or not known? Also note the presence of siblings who may also be affected, at risk or in need of support.*
- *If the client is a child not living with his or her biological parents, note who the child is living with, such as adoptive or step-parent or if in alternative care, such as foster or kinship care, note with whom. If in institutional care, note details of residential care facility, date and reason of entry, etc. (refer to specialized processes for children in residential care).*
- *Note significant stressors on or changes in family or other household member relationships.*
- *Record employment situation, including any stressors or recent changes.*

##### **B. PARENT /GUARDIAN/ CAREGIVER HEALTH AND WELL-BEING:**

- *Overall presenting issues that influence the child's risk, such as factors influencing ability to provide parental care, e.g., frailty, alcohol or drug dependence.*

- *Factors that present opportunities to protect child.*
- *Physical or mental illness, including long-term or chronic illness, such as HIV, that may reduce protective care of the child or create stigma.*
- *Disability-related factors that influence parent/guardian/caregiver ability to provide care.*
- *Evidence of domestic violence.*

#### C. CLIENT'S RELATIONSHIPS WITH IMMEDIATE FAMILY:

- *Any issues that may affect child's ability to express his or her wishes in front of adults, such as preventing access or free speech.*
- *Siblings who could provide care and support or who may also need protection.*

#### D. CLIENT'S RELATIONSHIPS WITH EXTENDED FAMILY:

- *Nature of parents'/guardians' relationships with other members of family and extended family, and how these may pose a risk or offer support to the child.*
- *Presence of relatives, including where they live, who may be able to offer support and help.*

### CLIENT'S PHYSICAL AND SOCIAL CIRCUMSTANCES

#### E. CLIENT'S PHYSICAL HEALTH:

- *Any physical concerns needing referral to health services, e.g., nutrition, sexual and reproductive health, HIV status or risk, access to medication for chronic illness.*
- *For HIV-related cases, refer to Job Aid 7.*
- *In case of disability, factors that expose the child to risk, e.g., lack of medical care, stigma or discrimination.*

#### F. CLIENT'S EMOTIONAL HEALTH:

- *Any immediate factors that place the child at risk, such as being fearful or traumatised.*
- *Presenting issues that may affect the child's level of risk, e.g., delinquent behaviour, anger or depression.*
- *Are any emotional health concerns recent or long-standing?*

#### G. EDUCATION:

- *Current school or training attendance, noting reasons for drop-out or infrequent attendance.*
- *Child's performance and security at school, including any recent changes.*

#### H. PHYSICAL ENVIRONMENT:

- *Present living circumstances.*
- *Level of physical safety of child.*
- *Family risk of losing accommodation or facing other shelter- and security-related stresses.*
- *If not living with parents, how long has the child lived here, and is the arrangement formal or informal?*
- *If a child-headed household, who is responsible for safety, and is child with any siblings?*

## I. HOUSING

- Describe accommodation and note ownership.

## J. SUPERVISION

- Level of parenting/adult supervision; include areas of strengths and challenges.

## K. NUTRITION

- Observations on nutrition status, frequency of meals and availability of food.

### PART 4 | LEVEL OF RISK AND NEXT STEPS

#### GUIDANCE FOR ASSESSING RISKS

It is not always easy to assess harm. The matrix gives some guidance on how to assess risk but **it is important to consider all the individual factors for each case.**

The matrix is **not a checklist**. The examples included cover the main areas of risk addressed by the Child Care and Protection Act, and illustrate the nature of risk and level of safety. A social worker must use his or her professional training and assessment to review the individual circumstances, which may include factors not included in this matrix.

When in doubt, assume that there is a high or medium risk and treat the case with urgency.

The person assessing the harm should follow these practices:

- *When you're not sure about something, contact a supervisor, senior colleague or colleague for guidance and support in making a decision.*
- *Talk to the child on his or her own, if possible, to find out whether he or she is at risk of serious harm and unable to talk in front of others, bearing in mind his or her age and maturity, gender and any special needs such as disability.*
- *Try to avoid a situation where the child has to repeat a traumatic experience on several occasions.*
- *Listen to caregivers and family members, also, to learn about their concerns, remembering that different people may have their own agendas. The priority is to find out if there is anyone who cares for the child and is in a position to protect the child from further harm, and who will not be intimidated by others.*
- *When possible, talk to other people who know the child, such as educators or religious leaders, to find out about any background context.*
- *Arrange for the child to be medically examined if appropriate.*
- *Secure immediate help if necessary.*

**MATRIX TO GUIDE RISK ASSESSMENT (ADAPTED FROM INTERAGENCY GUIDELINES ON CASE MANAGEMENT AND CHILD PROTECTION). THE EXAMPLES BELOW ARE ILLUSTRATIVE, AND ARE NOT TO BE USED AS A CHECKLIST.**

Type of harm	High risk / Not safe – emergency response required	Medium risk / Not safe – court proceedings or stay home	Low risk / Safe – referral for prevention/early intervention
<b>Violence</b> <i>(physical abuse)</i>	<ul style="list-style-type: none"> <li>• Serious injury requiring urgent emergency medical attention</li> <li>• Young child exposed to serious domestic violence</li> <li>• Child has uncontrolled violent behaviour</li> </ul>	<ul style="list-style-type: none"> <li>• Harsh corporal punishment leading to bruises or emotional harm</li> <li>• Child exposed to dangerous and reckless behaviour and/or domestic violence in home</li> </ul>	<ul style="list-style-type: none"> <li>• No violence present</li> <li>• Person causing violence has left the home with no plans for return</li> </ul>
<b>Abuse</b> <i>(sexual)</i>	<ul style="list-style-type: none"> <li>• Child currently exposed to sexual contact with an adult (where the adult has ongoing access to the child)</li> <li>• Child is being coerced into or has been abducted for marriage</li> <li>• Child is accused of perpetrating sexual abuse</li> </ul>	<ul style="list-style-type: none"> <li>• Child has been sexually abused in the past and received no support</li> <li>• Child is in coercive sexual relationship with someone in position of power, e.g. teacher</li> </ul>	<ul style="list-style-type: none"> <li>• Child and family have received support for previous sexual abuse and there is a protective adult in the home and no sexual harm factors present</li> </ul>
<b>Abuse</b> <i>(emotional)</i>	<ul style="list-style-type: none"> <li>• Child is being persistently belittled, isolated, or humiliated by a significant caregiver or encouraged by caregiver, and child expresses wish to be removed from situation</li> </ul>	<ul style="list-style-type: none"> <li>• Child is routinely exposed to belittling, isolation or humiliation</li> <li>• Child is treated differently and worse than other children in home</li> </ul>	<ul style="list-style-type: none"> <li>• Factors causing the emotional harm have been addressed (e.g. caregiver received support, change of caregiver)</li> <li>• Abuser no longer has contact with the child</li> </ul>
<b>Psychosocial distress</b>	<ul style="list-style-type: none"> <li>• Child has attempted suicide or significant self-harm or is having serious thoughts about suicide</li> <li>• Child is engaging in antisocial behaviour including violence, including being accused of perpetrating sexual violence</li> <li>• Child is addicted to drugs/alcohol</li> <li>• Child is refusing to go to school / running away</li> <li>• Child living and working on the streets</li> </ul>	<ul style="list-style-type: none"> <li>• Child's social skills, ability to self-care and attend school significantly impaired</li> <li>• Child is regularly angry or depressed</li> <li>• Child periodically is using drugs and/or alcohol</li> <li>• Child on the streets by day, but goes home at night</li> </ul>	<ul style="list-style-type: none"> <li>• Child not displaying behaviours of concern</li> <li>• The child has a significant caregiver who shows love and cares openly for the child</li> <li>• Child has experimented with drugs or alcohol, but not using routinely</li> </ul>
<b>Neglect</b>	<ul style="list-style-type: none"> <li>• Serious injury or illness due to neglect (e.g. malnutrition with no apparent cause, lack of support for HIV care)</li> <li>• Lack of supervision exposing child to risk of serious harm, e.g. young child left alone with kerosene stove</li> <li>• Abandonment</li> </ul>	<ul style="list-style-type: none"> <li>• Inadequate basic care</li> <li>• Lack of supervision for young child for a period of time / child undertakes tasks beyond capacity</li> <li>• Caregiver is emotionally distant</li> <li>• Family is receiving child grant but child is not benefiting (grant abuse)</li> </ul>	<ul style="list-style-type: none"> <li>• Child's basic needs are being met by the caregiver</li> <li>• The child has a significant caregiver who shows love and cares openly for the child</li> </ul>
<b>Exploitation and child labour</b>	<ul style="list-style-type: none"> <li>• Child involved in worst forms of child labour (sex work, harmful physical labour – ref to employment legislation)</li> <li>• Child is a victim of human trafficking</li> </ul>	<ul style="list-style-type: none"> <li>• Child involved in sporadic labour or domestic work that interrupts schooling</li> </ul>	<ul style="list-style-type: none"> <li>• The child is no longer working and is receiving support to return to school, etc., family is being supportive so child is not at risk of having to return to work</li> </ul>
<b>Health issues and/or HIV</b>	<ul style="list-style-type: none"> <li>• Child extremely ill (incl. HIV-related)</li> <li>• Child struggling with adherence to appointments &amp; medications (incl. ARVs)</li> <li>• Child with chronic illness has no level of support.</li> <li>• Child older than 12, but HIV status not yet disclosed and/or is in a sexual relationship</li> <li>• Child is no longer attending school due to illness (incl. HIV)</li> </ul>	<ul style="list-style-type: none"> <li>• The child is questioning or has poor understanding about his health and need to take medication, including ARVs</li> <li>• The child is being bullied at school about illness, including HIV.</li> <li>• Child recently disclosed to and may be adjusting to status</li> <li>• Disclosure plan and support needed</li> </ul>	<ul style="list-style-type: none"> <li>• The child is medically stable/virally suppressed. No barriers to care or adherence.</li> <li>• Child disclosed to and has a strong support system</li> <li>• The child may benefit from ongoing proactive support in case unexpected issues arise</li> </ul>

#### **PART 4 | LEVEL OF RISK AND NEXT STEPS**

The social worker will first need to ensure that there is sufficient information available, and then apply the findings to assess risk. First, review the checklist below to ensure that there is information available to make a decision and recommendation:

- Immediate action has been taken in case of risk to life or safety of child – police and social workers have worked together.*
- Social worker has had a chance to hear the child’s wishes and feelings and assess level of resilience of child in the short-term.*
- Social worker has talked to parents /guardians/ caregivers and heard their views, including whether they believe the child.*
- Social worker has talked to others, including to alleged perpetrator directly or with police, to get the fullest possible picture.*
- Social worker has assessed whether there is anyone who has care of the child who is in a position to protect the child from further harm, noting potential authority and influence over others of alleged perpetrator[s] that may affect any ability to provide protective care of child at home.*
- Social worker has sufficient information from above assessment to assess how likely that harm will happen again, and how serious it would be if that harm were to occur, and has noted this assessment in the box below.*
- Social worker has had a chance to assess whether alleged harm could have happened accidentally, and whether a responsible parent, guardian or caregiver could not have reasonably been expected to predict or prevent the incident.*

#### **WHAT ARE THE MOST IMPORTANT CONSIDERATIONS YOU MUST TAKE INTO ACCOUNT WHEN MAKING A RECOMMENDATION?**

- *How great is the risk to which the child is exposed (high, medium or low), based on the type of harm that has occurred or may occur? How serious would it be if it did occur again?*
- *Could the harm that has occurred have been accidental, or is it obvious that it was caused by a deliberate act perpetrated by someone else and/or caused by neglect and lack of care by a caregiver?*
- *Is there someone in the child’s family who can be trusted to keep the child safe from harm?*

If the child is at no identifiable risk of harm, the incident must still be documented and the social worker should consider what referrals should be made for prevention and early intervention.

Having considered the findings, the social worker will decide whether the case is low, medium or high risk, and will explain the reasons for their decision.

#### **PART 5 | CASE ACTION**

The social worker will note here any actions taken and referrals made, and make recommendations with regard to follow-up. It is essential that the supervisor reviews the decision, makes relevant notes and signs off.

#### **PART 6 | CLIENT CONSENT**

As indicated in **Job Aid 8**, social workers should seek consent from clients (including children) whenever possible. This consent can often be verbal, but at times it may be necessary and good practice to get a client’s consent in writing. Confidentiality practices among professionals can be limiting at times, so a written consent may be needed to allow for enhanced communication.

This practice is important to both the client and others, especially when the client's case will be shared between professionals. Two examples are:

- *A social worker who refers a child to a psychologist may want to explore how a child is doing to plan follow-up with actions in the child's best interest.*
- *A social worker working with a school-age child who may need some extra support/guidance during the school year is working with a life skills teacher, whom the child has a good relationship with. Having a written consent can officially allow periodic communication about case-relevant information.*

The meaning and practice of the consent always need to be fully explained to a client. A client must always understand what they are signing and offering permission for. A client offering consent does not imply that all information can be shared, only appropriate case-relevant information. The consent can be unrestricted, meaning the client is offering permission to discuss her/his case as needed. A client also has the right to give a limited consent (and if so, any limitations should be documented).

- *A social worker working with a school-age child knows that the child is living with HIV. While the child is supportive of the social worker communicating with the life skills teacher, the child does not yet want the teacher to know about his/her HIV status. Therefore, a sentence could be written conferring 'permission to discuss general well-being and school related issues'. This clarifies a restriction that prevents the discussion of health issues.*
- *A client is a minor in school. As it may be challenging for a social worker to go and visit the child in the school setting, a client (child and/or parents) can grant official permission to the social worker to contact the life skills teacher or a school counsellor.*



## CM 2: Intake and risk assessment | Part 1: Client demographic profile

Part 1 MUST be reviewed at each visit/contact with the client and any change in information must be noted below, with a date when the information was changed.

Particulars of the person making the report / referral		Reporting / intake date(s): DD / MM / YYYY	
Name:		DOB / ID: DD / MM / YYYY	
Contact number:	Address:		
Reporter: <input type="checkbox"/> Self-referral <input type="checkbox"/> Family/Friend <input type="checkbox"/> Professional <input type="checkbox"/> Other:		Professional: Organization / Practice # (if applicable):	
Home language:	Marital status:	Occupation:	
Citizenship:	If student, school:	Grade / year:	
Client Demographic Profile	Additional Intake Date(s): DD / MM / YYYY		MGECW Ref #:
Client's surname:	First name:		Home name (if different):
Date of birth: DD / MM / YYYY	Age:	ID:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Marital status (if applicable): <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Cohabiting <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			
Address/ERF no/location/village/constituency:		Cell: Other tel:	
Citizenship: <input type="checkbox"/> Namibian <input type="checkbox"/> Unknown <input type="checkbox"/> Other:		Birth certificate copied: <input type="checkbox"/> Yes <input type="checkbox"/> No Home language:	
<b>Next of kin name:</b> Relationship to client: Cell: Other tel: Address: <input type="checkbox"/> Same as above <input type="checkbox"/> Different (write below)		If student, school and grade: Best way to reach client or family: Child-headed household: <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Previous history with MGECW:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, MGECW office: Social Worker:		If yes, other MGECW reference no.: When/Reason: File(s) located: <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>External support:</b> Any other support and/or agencies working with client: <input type="checkbox"/> Yes <input type="checkbox"/> No If so, who/connection:		<b>Existing reference nos.</b> (if exists) <input type="checkbox"/> Court <input type="checkbox"/> Police criminal record <input type="checkbox"/> Other, please specify:	
Updates: Note any contact detail changes (continue on blank page if needed):			
	DD / MM / YYYY		DD / MM / YYYY
	DD / MM / YYYY		DD / MM / YYYY
	DD / MM / YYYY		DD / MM / YYYY



<b>Family information as applicable</b>			
<b>Other(s) connected to the case/client</b> <i>(Use a blank page for additional space if needed)</i>			
Mother surname:		First names:	
Date of birth: DD / MM / YYYY ID:		Date of birth: DD / MM / YYYY ID:	
<input type="checkbox"/> Alive <input type="checkbox"/> Dead <input type="checkbox"/> Unknown	Resides with client: <input type="checkbox"/> Yes <input type="checkbox"/> No	Cell: Address <i>(if different)</i> :	Other tel: Occupation: Monthly income:
Father surname:		First names:	
Date of birth: DD / MM / YYYY ID:		Date of birth: DD / MM / YYYY ID:	
<input type="checkbox"/> Alive <input type="checkbox"/> Dead <input type="checkbox"/> Unknown	Resides with client: <input type="checkbox"/> Yes <input type="checkbox"/> No	Cell: Address <i>(if different)</i> :	Other tel: Occupation: Monthly income:
<b>Other(s) connected to the case / client</b> <i>(use a blank page for additional space if needed. For complainants and respondents, complete part 7)</i>			
Other children: <input type="checkbox"/> Yes, how many?: <input type="checkbox"/> No			
Surname:		First names:	
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Date of birth: DD / MM / YYYY ID: School / Grade:	Contact info same as client: <input type="checkbox"/> Yes <input type="checkbox"/> No if not please provide:		Relationship to client:
Surname:		First names:	
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Date of birth: DD / MM / YYYY ID: School / Grade:	Contact info same as client: <input type="checkbox"/> Yes <input type="checkbox"/> No if not please provide:		Relationship to client:
Surname:		First names:	
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Date of birth: DD / MM / YYYY ID: School / Grade:	Contact info same as client: <input type="checkbox"/> Yes <input type="checkbox"/> No if not please provide:		Relationship to client:
Surname:		First names:	
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Date of birth: DD / MM / YYYY ID: School / Grade:	Contact info same as client: <input type="checkbox"/> Yes <input type="checkbox"/> No if not please provide:		Relationship to client:
<b>ANY OTHER ISSUES NEEDING SUPPORT/ATTENTION:</b> <i>(Use a blank page for additional space if needed)</i>			
Completed by:		Signature:	
Date: DD / MM / YYYY		Date: DD / MM / YYYY	





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## Additional Ecomaps / Genograms

Client surname / first name:

MGECW Ref #:

Rapid risk assessment family profile and impact on client	Notes / supporting evidence
<p><b>• Family background and composition:</b></p> <p><input type="checkbox"/> Good / safe</p> <p><input type="checkbox"/> Recent changes (family income / wellbeing / household members)</p> <p><input type="checkbox"/> Challenges (unemployment / family breakdown / alcohol use)</p> <p><input type="checkbox"/> Unpredictable context (alcohol-related or domestic violence)</p>	
<p><b>• Parent/guardian health and wellbeing:</b></p> <p><input type="checkbox"/> In good health</p> <p><input type="checkbox"/> Health or wellbeing concerns but receiving support e.g. medication, disability support</p> <p><input type="checkbox"/> Fragile / regularly sick / inconsistent health</p> <p><input type="checkbox"/> Significant issues (e.g. chronic health issue, living with HIV, physical and/or mental disability, substance dependence)</p>	
<p><b>• Client relationships with immediate family:</b></p> <p><input type="checkbox"/> Good    <input type="checkbox"/> Non-existent / poor    <input type="checkbox"/> Inconsistent / unstable</p>	
<p><b>• Client relationships with extended family:</b></p> <p><input type="checkbox"/> Good    <input type="checkbox"/> Non-existent / poor    <input type="checkbox"/> Inconsistent / unstable</p>	
Client physical and social circumstances	Notes / supporting evidence
<p><b>• Client's physical health:</b></p> <p><input type="checkbox"/> In good health</p> <p><input type="checkbox"/> Health or wellbeing concerns but receiving support (medication, disability support)</p> <p><input type="checkbox"/> Health or wellbeing concerns requiring assessment / support</p> <p><input type="checkbox"/> Chronic health issue (HIV) See job aid 7</p> <p><input type="checkbox"/> Health vulnerability (disability, substance abuse, other)</p>	
<p><b>• Client's emotional health:</b></p> <p><input type="checkbox"/> In good health</p> <p><input type="checkbox"/> Health or wellbeing concerns but receiving support, (medication, disability support)</p> <p><input type="checkbox"/> Health or wellbeing concerns requiring assessment / support</p> <p><input type="checkbox"/> Significant Issues (poverty, suicidal, mental distress, negative thoughts towards self or others that could lead to self-harm or criminal activity)</p>	
<p><b>• Education:</b>    Feels safe at school:    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p><input type="checkbox"/> In school</p> <p><input type="checkbox"/> Poor attendance</p> <p><input type="checkbox"/> No longer attending school</p> <p><input type="checkbox"/> Never attended school</p>	

Client surname / first name:

MGECW Ref #:

Physical environment	Notes / supporting evidence
<p>• <b>Present living circumstances:</b></p> <ul style="list-style-type: none"><li><input type="checkbox"/> <i>Good / safe</i></li><li><input type="checkbox"/> <i>Okay / safe</i></li><li><input type="checkbox"/> <i>Inconsistent / varies</i></li><li><input type="checkbox"/> <i>Unsafe</i></li></ul>	
<p>• <b>Housing</b> <i>(type, size, ownership, impression):</i></p>	
<p>• <b>Level of parenting supervision:</b></p> <ul style="list-style-type: none"><li><input type="checkbox"/> <i>High / good</i>      <input type="checkbox"/> <i>Non-existent / dysfunctional</i></li><li><input type="checkbox"/> <i>Inconsistent / varies</i></li></ul>	
<p>• <b>Food:</b></p> <ul style="list-style-type: none"><li><input type="checkbox"/> <i>Access to healthy food at least twice daily</i></li><li><input type="checkbox"/> <i>Inconsistent (e.g. often goes to bed without a meal)</i></li><li><input type="checkbox"/> <i>Significant issues (e.g. signs of malnutrition)</i></li></ul>	
Child justice background	Notes / supporting evidence in relation to criminal history
<p><b>Previous criminal behaviour / history</b> <i>(check all that apply)</i></p> <ul style="list-style-type: none"><li><input type="checkbox"/> <i>Previous criminal behaviour (not resulting in arrest) (e.g. physical fighting, aggressive behaviour, petty theft, vandalism)</i></li><li><input type="checkbox"/> <i>Previous arrests</i>   <input type="checkbox"/> <i>yes</i>   <input type="checkbox"/> <i>no</i></li><li><input type="checkbox"/> <i>Previous convictions</i>   <input type="checkbox"/> <i>yes</i>   <input type="checkbox"/> <i>no</i></li><li><input type="checkbox"/> <i>Previous interventions (e.g. diversion, community service)</i></li></ul>	
<p><b>Any additional notes:</b></p>	



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## CM 2: Intake and risk assessment | Part 4: Status of risk and next steps

Client surname / first name:

MGECW Ref #:

**Level of risk and next steps:** (Refer to Matrix and guidance on risk assessment and mark the relevant box with an X)

**No / low risk (safe)**

*Referral to others as needed with monitoring or address the situation as appropriate*

**Medium risk (safe at present, but potential for increased risk)**

*Further investigation and support required while child stays at home.*

**High risk (not safe)**

*Immediate action required to protect the child from harm such as physical violence, sexual violence, emotional violence, extreme neglect, exploitation and child labour, etc.*

**Briefly explain your observations and reason for selecting option, with recommendations:**



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## CM 2: Intake and risk assessment | Part 5: Case action

Client surname / first name:

MGECW Ref #:

### Case action *(Note any actions and referrals made to other service providers)*

**Actions done for this intake:**

- Crisis management
- Offered psychosocial support
- Provided counselling / therapy
- Offered information and resources
- Assisted with care plan
- Collaborated with stakeholders
- Home visit
- Other:

**Case status / recommendation:**

- Issues addressed, no follow up needed
- Follow up needed, but social investigation not required
- Social investigation and care plan required *(mandatory for all children with medium or high risk)*

Supervisor notes:

Social worker name:

Signature:

Date: DD / MM / YYYY

Supervisor name:

Signature:

Date: DD / MM / YYYY

Official stamp:



Client surname / first name:

MGECW Ref #:

**Consent to receive case management services and support (See Job aid 9)**

The Ministry of Gender Equality and Child Welfare provides services and support so that all children are protected and cared for, and so that all families are able to provide care and support for their children.

The following MGECW \_\_\_\_\_ Office, seeks to provide support / services to:

\_\_\_\_\_  
\_\_\_\_\_

**So that we know you have read and understood this agreement please answer yes or no to each of the following statements by placing a cross in the box.**

**The information that you provide will not be shared with anyone unless:**

- You consent to the information being shared. Each time the social worker suggests that the information be shared you will have a chance to confirm your permission.  Yes  No
- You or any of your children are likely to be seriously hurt.  Yes  No

I understand that any social work court report filed will become public record.  Yes  No

The above has been explained to me and any questions have been addressed.  Yes  No

Name of client and/or guardian:

Signature:

Date:  
DD / MM / YYYY

Name of Social Worker:

Signature:

Date:  
DD / MM / YYYY

Organisation name, if any	Contact person	Permission to share	Date	Client initials
		<input type="checkbox"/> Yes <input type="checkbox"/> No	DD / MM / YYYY	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	DD / MM / YYYY	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	DD / MM / YYYY	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	DD / MM / YYYY	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	DD / MM / YYYY	



## CM 2: Intake and risk assessment | Part 7: Respondent / complainant information

Respondents / Complainant can be alleged perpetrators, victims of crime or anyone needing to be interviewed around a case/investigation.

Client surname / first name:

MGECW Ref #:

**Information as applicable** (If more than one respondent / complainant, please use a separate form for each)

Surname:		First names:		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Date of birth: DD / MM / YYYY	Occupation:	Cell:	Other tel:	Relationship to client:	
ID:		Address (if different from client):		Are they aware of complaint or case? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Date(s) of interview(s): DD / MM / YYYY ; DD / MM / YYYY

Notes / observations by and on:

Recommendations / actions:

For GBV, were any children involved in, witness, or live with respondent / complainant? (If yes, complete risk assessment)

Yes  No





## STEP 3: SOCIAL INVESTIGATION AND CARE PLAN

### WHAT IS THE PURPOSE OF THIS STEP?

The **social investigation (Form CM3)** is a full assessment of the client’s situation in order to identify an appropriate response. The social investigation explores underlying reasons for the risks faced by the client, and the strengths and resilience of the client and family in order to mitigate the risks. The social investigation form CM3: consists of four distinct, but interrelated parts:

- Part 1: Client and Case Review
- Part 2: Social Investigation
- Part 3: Child’s Voice/Child’s Well-being
- Part 4: Care Plan
- Form CM3a: a specialised report in cases of children in conflict with the law; child in conflict with the law.

### CARE PLAN (CM3, PART 4)

- *A care plan sets individual goals that are directly relevant to the child’s problems, and are measurable and realistically achievable within a set time frame for all actors.*
- *A care plan identifies changes necessary to remove the child from the risk of harm and to promote the child’s well-being, building on the strengths and challenges noted in Form CM3.*
- *It is essential that the child and trusted family members/ guardians, when appropriate, contribute to and agree on proposed goals.*
- *It is important to note that the development of a care plan is applicable to all children who have been assessed, regardless of whether a child has been removed or remains at home.*
- *Developing a care plan requires involvement of other important actors who can provide the necessary support and interventions. These may include prevention and early intervention (parenting support for mother or life skills for child), and other specialised services, such as education guidance, disability support, HIV counselling, etc.*

### IS THIS MANDATORY?

The **social investigation** is conducted on all children who have been assessed as ‘medium risk’ or ‘high risk’ during intake and risk assessment. It focuses on underlying strengths and challenges. This form must be completed for all children whose case must appear before a children’s commissioner.

This includes:

- A. All children for whom a warrant was issued under **CCPA Article 134:2**, for their removal or the removal of an alleged offender;
- B. All children who require placement in alternative care – this includes all children who fall under **CCPA Article 131:1** and who lack a suitable caregiver;
- C. Children who fall under **CCPA Article 131:2** and for whom the social worker decides, after the social investigation, that there should be a formal court record of proceedings.

The specialised form CM3a must be completed when a child is in conflict with the law. The form captures the criminal history, the motivation for the crime and other pertinent information from the point of view of the child.

The CCPA does not make reference to a **care plan** directly, except in the case of court proceedings, either for a child in conflict with the law or in need of protective services. However, it is essential, as part of good social work and case management practice, to have a care plan, developed with and agreed-upon by the child and family and all other actors with a role to play.

### WHAT IS THE OUTCOME?

A detailed Social investigation considers the risks identified at initial risk assessment stage and in a more detailed review of the child's and family's wishes, strengths and challenges which require supportive interventions. A plan for the child to receive ongoing, tailored support is developed and initiated. Where needed, a court report is produced and is a legal record.

### GUIDANCE FOR COMPLETING FORM CM 3: SOCIAL INVESTIGATION

The social investigation is conducted on all clients who have been assessed as 'medium risk' or 'high risk' during intake and risk assessment. It focuses on the underlying strengths and challenges for child and family, which are gathered by the social worker.

The form must be completed for all clients who have been assessed using **Form CM2** and have been assigned to a social worker for protective services.

The objective of the form is to review and build upon the information documented in CM2: Intake and Risk Assessment by recording more comprehensive details, identifying:

- *additional information, updates, observations or causes for concern;*
- *the strengths possessed by client, family and community to meet specific needs;*
- *the child's own views of his or her well-being.*

The focus is on the total protective environment of the client – siblings, parents/guardians/caregivers, extended family, peers and the broader community.

**Strengths-based assessment** is an important principle. The child and family may already have good ideas about what is working and not working. It is also useful for a social worker to start the discussion by focusing on the positive – talk to the child and family about things that are working very well. Ask them if this always happens, and only then focus on why the good things do not always go well.

Once the challenges have been identified, first look at what might already be addressed by doing things differently – what would make it possible for the child or adult to make the change that is concrete and achievable?

A case conference might be a way to bring in expertise from others in the community to suggest possible solutions.

Review **Job Aid 4: Strengths-based and resilience-based approaches to case management** when undertaking a social investigation. You may find the strengths-finder tool useful.

**Note:** Completing **Form CM3** may require a number of visits and interviews and possibly case conferences. Use the **process note** to record the date and content of each meeting and telephone conversation conducted.

A supervisor must review and countersign Forms **CM3** and **CM3a**.

**GUIDANCE ON SPECIFIC SECTIONS:****PART 1 | CLIENT AND CASE REVIEW**

Note any changes in contact details and update the demographic section of CM2 accordingly. Changes in living arrangements should also be noted.

After reviewing **CM2: Intake and Risk Assessment**, the space on page 1 should be used to make notes on actions taken, as well as to record any additional information, updates, observations or causes for concern. Note sufficient details to inform the analytical assessment of the case, and to ensure that the key issues affecting a child's level of care and support can be reviewed.

**PART 2 | CLIENT AND FAMILY PROFILE**

After reviewing **CM2**, add more comprehensive details and deepen the analysis. It is important to examine the underlying causes of risks and to identify the key challenges, as well as the strengths which can be harnessed to address the challenges. The headings trigger the social worker to think about all the influences on a child's well-being and safety.

The following are the types of issues that might be covered by the social worker during his or her interviews with the child, caregivers and other family and/or community members<sup>11</sup>:

**A. CAPACITY OF THE PARENTS/GUARDIANS/CAREGIVERS TO KEEP THE CHILD SAFE AND PROMOTE THE CHILD'S DEVELOPMENT:**

- *Does the parent/guardian provide basic care (food, drink, shelter and appropriate clothing and adequate personal hygiene)? Does the parent/guardian/caregiver arrange for appropriate medical care and meet the child's physical needs? If not, is it because the parent/guardian/caregiver is not able to, or chooses not to?*
- *Does the parent/guardian/caregiver ensure that the child is safe (recognise and take measures to avoid hazards that exist in the home and elsewhere, protect the child from significant contact with unsafe adults or other children and from self-harm)?*
- *Does the parent/guardian/caregiver ensure that the child's emotional needs are met, and give the child a sense of being valued and a positive sense of their own cultural and racial identity by providing a secure, stable and affectionate relationship and facilitating such relationships with others? Does the parent/guardian/caregiver praise and encourage the child and offer physical contact to provide comfort, including cuddling?*
- *Does the parent/guardian/caregiver provide stimulation and support learning (by providing encouragement, stimulation, promoting learning opportunities, etc.)? Does the parent/guardian/caregiver play, talk and respond to the child's questions? Does the parent/guardian/caregiver facilitate school attendance and help the child to meet the challenges of life?*
- *Does the parent/guardian/caregiver encourage emotional development by modelling examples of appropriate behaviour? Does the parent/guardian/caregiver have skills in social problem solving, anger management, consideration or others and self-discipline? If not, is the parent/guardian/caregiver receiving the tools/support necessary to develop these skills?*
- *Does the parent/guardian/caregiver provide a stable family environment (including consistent emotional warmth and maintaining contact with important family members and significant others)?*

<sup>11</sup> These questions have been adapted from Department of Social Welfare, Republic of Tanzania: Child Protection Case Management System.

## B. CHILD'S DEVELOPMENTAL NEEDS

- *Are the child's health development needs met, including appropriate health care being provided when the child is ill, adequate and nutritious diet, exercise, preventive health care (such as immunisation), appropriate advice and information on issues that have an impact on health, including protection from sexual harm and the misuse of drugs?*
- *Does the child have opportunities to go to ECD, school and higher or vocational education, including the chance to interact with other children, access books, acquire a range of skills and interests, and have the chance to experience success and achievement? Are there one or more adults who take an active interest in the child's educational progress and achievements? Are any special educational needs being assessed and support accessed?*
- *Does the child demonstrate quality attachments with the parent/guardian/caregiver or other significant adults? Is the child given the chance to demonstrate, with feelings and actions, an appropriate response to other people and to adapt to change?*

## C. FAMILY AND SOCIAL RELATIONSHIPS

- *Does the child have stable and affectionate relationships with parent/guardian/caregiver, good relationships with siblings and others in the household, and age-appropriate friendships with peers? Are the child's external friendships accepted by the family?*
- *Is the child able to present him- or herself appropriately to the outside world and have a positive sense of his or her own appearance and behaviour? Does the child have a positive self-image in relation to factors such as positive HIV status or disability?*
- *Has the child been taught self-care skills appropriate to age and developmental stage, such as cleanliness and personal hygiene and practical household skills? Is the child growing in independence?*
- *Is the child encouraged to acquire social problem-solving approaches?*
- *Have any significant life events influenced the child's family context, such as death or migration? In cases of an absent parent or parents, is the child able to see the parent[s] if alive, and to understand the context?*

## D. HOUSING AND MEETING PHYSICAL NEEDS

- *Does the housing meet the needs of the child and other members of the family, particularly if the child has a disability?*
- *Are there basic amenities available? Are the house and immediate surroundings safe and hygienic?*
- *Are the sleeping arrangements appropriate to the child's age and gender?*
- *Who is engaged in regular work? How does the presence or absence of work reflect upon and influence the child? Do family members access grants or other forms of social protection support?*

## E. COMMUNITY AND ENVIRONMENT

- *Do the child and family have peer groups, friends and social networks? What importance is attached to these friends and networks? What impact does the local neighbourhood and community have on the child and parent/guardian/caregiver?*
- *What resources are available in the community, including education, leisure, worship and healthcare? Are there any transport issues? What impact does this level of resource availability have on the child and family?*

### **PART 3 | CHILD'S VOICE**

**This section of the form is vital to ensure that the child's own perspectives have been clearly heard.**

While the social worker's own assessment and the views of key adults in the child's life are critical, it is also very important to understand and take into account the child's own perspectives on his/her well-being and any decisions being made.

The case manager should use the **child's well-being indicators** to identify the child's perspectives on the case. However, note that this should be used sensitively and introduced at a point when the child has trust that his or her opinions will be heard, and only when the child is developmentally capable of understanding (normally around age 6). The child's responses should be recorded on the form. **It should not be the social worker's assessment of the score.**

The questionnaire will normally be completed together with the child, with the social worker explaining the exercise and reading out the statements. The child will be encouraged to point to the place on the smiley face/number spectrum which best corresponds with her/his own feelings and experience. The social worker will mark the form accordingly in the presence of the child.

Additionally, based on the answers, the social worker can probe deeper to get as clear a picture as possible of the factors which affected the answers, including:

#### **A. OVERALL SENSE OF HAPPINESS:**

- *Factors affecting overall sense of safety (at home, at school)*
- *Factors affecting overall sense of social inclusion*
- *Factors affecting overall sense of level of care*

#### **B. DEPENDING ON THE SITUATION, ALSO ASK THE CHILD DIRECTLY:**

- *Who does he/she think should care for him/her*
- *Ideas for how to stay safe and make things good in the future*

The **strength-finder tool from Job Aid 4** is included on the back of the well-being indicator tool, and may be useful as an additional or alternative method for working with the child.

**Other useful tools can be found in Job Aid 9: The Interviewing Hand Model, as well as Job Aid 4: Strengths-based and resilience-based approaches.**

### **PART 4: CARE PLAN**

Any child who enters the child protection system must have a care plan that indicates how that child and family will be assisted in order to improve the child's circumstance, decrease the risks the child faces, and improve the capacity of the parent/guardian/caregiver to care for the child(ren), thus preserving the family. A care plan:

- *Sets out individual goals that are directly relevant to the child's problems.*
- *Is able to be measured and realistically achievable within a set time frame for all actors, and consists of time-bound action steps.*

- *Must include goals for the child and other family members. Actions must clearly state roles and responsibilities and timelines. It is essential that the child and trusted family members/ guardians, where appropriate, contribute to and agree upon proposed goals.*
- *Must address changes necessary to remove the child from being at risk of harm and to promote the child's well-being, building on the strengths and challenges noted in Form CM3.*

It is important to note that the development of a **care plan** is applicable to all children who have been assessed, irrespective of whether a child has been removed or remains at home.

Developing a care plan requires involvement of other important actors who can provide the necessary support and interventions. These may include prevention and early intervention (parenting support for mother or life skills for child), and other specialised services – education guidance, disability support, HIV counselling, etc.

This document is a formal record of the steps agreed upon by the child, caregiver, any other significant actors in the case and the social worker. A copy of the care plan should be provided to each person named in the plan as deemed appropriate by the social worker. The care plan should be informed by the findings documented in **Parts 1, 2 and 3**, and any case conference meetings that are held should be recorded on **Form CM6: Case Conference Record**.

#### **A. CHILD'S GOALS:**

- *Present a clear statement of what the child would like to achieve.*
- *Make these measurable (avoid statements such as 'feeling happy at home', rather identify specific targets focused on changing what is making the child unhappy, such as 'having my mother spend time with me for at least some time each day').*
- *The process of developing the child's goals focuses on talking to the child, and counselling and supporting the child so that the child can identify her/his own solutions or identify who can resolve challenges.*
- *Make sure that the child's goals are not dependent on others (for example, a goal of removing an abusive stepfather from the home is more suitable as a social worker goal).*

#### **B. PARENT/GUARDIAN/CAREGIVER GOALS:**

Follow the same basic pattern as for child's goals, above.

#### **C. SOCIAL WORKER GOALS:**

- *These may be the more complex issues that require addressing.*
- *This is an opportunity for the social worker to ensure that child and parent/guardian/caregiver agree on the approach.*
- *Social worker goals should be shared with the child and parent/guardian/caregiver, and collectively understood and agreed upon.*

#### **D. AGREED PLAN OF ACTION:**

- *Prepare an overview of the end results, and identify all key actors and how they are to be involved.*
- *Break the overall agreed-upon plan of action into separate, realistic and measurable targets, ensuring that they are time-bound and manageable.*

- *Note all actors involved in the plan. It may be necessary to have a number of meetings to develop an action plan. A final copy of the plan should be shared with all core members of the care plan.*
- *Child and family agreement:*
- *Take the time to explain what is written down, ensuring that the child and family understand the decisions, understand the next steps and process, and fully consent.*
- *The plan can be explained clearly and repeated if necessary, especially for children and/or parents/guardians/caregivers who cannot read.*
- *If child or family member disagrees, note why it is still included and what actions are being done to approve the process.*
- *As the case progresses, note progress and new action points on the care plan. This plan is the base plan with case conference notes included in the case file next to this plan.*

**CM 3: Social investigation | Part 1: Client and case review**

Form CM 3 is completed for all clients who have been assessed using Form CM 2 and have been assigned to a social worker for protective services

<b>Client and case review</b>	<b>Date(s):</b> DD / MM / YYYY ; DD / MM / YYYY DD / MM / YYYY ; DD / MM / YYYY	<b>MGECW Ref #:</b>
Client's surname:	First names:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
<p>Any changes in contact details? <input type="checkbox"/> Yes <input type="checkbox"/> No    If yes, demographic profile section updated: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Describe any changes in living arrangements below:</p>		
<b>Case Review</b> (Review intake and note additional information, updates, observations and / or causes for concern)		
<p style="text-align: right;">Actions done during social investigation visit(s):</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Crisis management</li> <li><input type="checkbox"/> Offered psychosocial support</li> <li><input type="checkbox"/> Provided counselling and therapy</li> <li><input type="checkbox"/> Offered information and resources</li> <li><input type="checkbox"/> Assisted with care plan</li> <li><input type="checkbox"/> Collaborated with stakeholders</li> <li><input type="checkbox"/> Home visit</li> <li><input type="checkbox"/> Other:</li> </ul>		



Client surname / first name:

MGECW Ref #:

**Client profile, strengths and challenges** *(In review of Form CM 2, provide additional / more comprehensive details about client's circumstances. Explore and note strengths and challenges.)*

**Behavioural and psychological development**

**Emotional health and personality**

**Physical health** *(including any HIV-related issues that are in need of support – see job aid 7)*

**Education and school attendance / performance**

**Client's relationship with peers and others in the community**

**Leisure and recreational activities**

**Social, religious and cultural aspects**

Client surname / first name:

MGECW Ref #:

**Family profile, strengths and challenges** *(In review of Form CM 2, provide additional / more comprehensive details about client's circumstances. Explore and note strengths and challenges.)*

*Copy this page for any prospective guardian arrangements if a separate assessment is required.*

**Family background / composition / dynamics**

**Relationships *(including custody and access)* with parents / guardians / caregivers and siblings**

**Relationship with extended family**

**Housing and living situation**

**Financial circumstances *(employment, social grants, etc)***

**Factors affecting overall sense of level of safety and care**

**Child's ideas for how to stay safe and make things better**

**If relevant to case, who does the child think they should be cared for by?**

**Parents / guardians / caregivers health and wellbeing**

**Does anyone in the household have any HIV-related issues that are in need of extra support?**



Ministry of Gender Equality and Child Welfare

**CM 3: Social investigation** | Part 3: Child's voice / children's wellbeing indicators

Client surname / first name:

MGECW Ref #:

<b>Child's name:</b>		<b>Date:</b> DD / MM / YYYY				
<b>Satisfaction Scale:</b> 1 - Never / not at all    2 – Almost never    3 – Sometimes    4 – Almost always    5-Always						
<b>Home and family</b>						<i>Notes / comments (child's own words if possible)</i>
<i>I feel safe at home</i>	1	2	3	4	5	
<i>My parents (or the people who look after me) listen to me and take what I say into account</i>	1	2	3	4	5	
<i>My parents (or the people who look after me) treat me fairly</i>	1	2	3	4	5	
<b>Warmth and affection:</b> How often in the past week have you spent time doing the following things with your family?						
<i>Talking together</i>	1	2	3	4	5	
<i>Having fun together</i>	1	2	3	4	5	
<i>Learning together</i>	1	2	3	4	5	
<b>Friends</b>						
<i>I have at least one good friend that cares about me</i>	1	2	3	4	5	
<i>My friends are usually nice to me</i>	1	2	3	4	5	
How often in the past week have you spent time doing the following things with your friends, apart from school?						
<i>Talking together</i>	1	2	3	4	5	
<i>Having fun together</i>	1	2	3	4	5	
<b>School</b>						
<i>I enjoy school</i>	1	2	3	4	5	
<i>I feel safe and supported at school</i>	1	2	3	4	5	
<b>Self</b>						
<i>I like the way I look</i>	1	2	3	4	5	
<i>I feel self-confident</i>	1	2	3	4	5	
<i>I have opportunities to improve my life</i>	1	2	3	4	5	
<b>Overall life satisfaction</b>						
<i>My life is going well</i>	1	2	3	4	5	
<i>I am happy</i>	1	2	3	4	5	
<i>feel positive about my future</i>	1	2	3	4	5	



STRENGTHS-FINDER TOOL			
What makes me feel safe and secure	Where am I already strong?	What makes it hard to be strong?	What would help in making things better? Where can I get support?
<p><b>How I grow and develop</b></p> <p><i>Health</i></p> <p><i>Education</i></p> <p><i>Communication with important people</i></p> <p><i>Learning how to look after myself</i></p> <p><i>Being confident and being believed</i></p>			
<p><b>What I need from the people around me</b></p> <p><i>Providing guidance</i></p> <p><i>Providing stability</i></p> <p><i>Providing space to play and have fun</i></p> <p><i>Spending time with family and friends</i></p> <p><i>Being kept safe</i></p> <p><i>Providing everyday care and help</i></p>			
<p><b>What I need from the outer world</b></p> <p><i>Being able to go to school or training</i></p> <p><i>Having access to health care</i></p> <p><i>To feel safe in the community</i></p> <p><i>Knowing where to go when things are not safe</i></p> <p><i>Having a safe place to live</i></p> <p><i>Having enough money in the home</i></p>			



**CM 3: Social investigation | Part 4: Care Plan**

Client surname / first name:

MGECW Ref #:

Care Plan: Identifying details of child		Date of completion: DD / MM / YYYY
Client's Surname:	First name:	Date of birth: DD / MM / YYYY
		Age:
Short term (next 3 months):	Medium term (next 12 months):	Long-term (beyond one year):
Client's goals:		
Parent / guardian / caregiver goals <i>(if appropriate):</i>		
Social Worker's goals:		



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### CM 3: Social investigation | Part 4: Care Plan

Client surname / first name:

MGECW Ref #:

**Care plan actions and agreement: By signing the below, I agree to the following:**

- *I have participated in discussions with the parties listed below and understand the written recommended actions. Any objections and/or disagreements are noted.*
- **Client/guardian:** *I agree for information directly related to this care plan to be shared, when necessary, with those cited or involved in this care plan meeting.*

*I understand that any information shared in a court report will be public record.*

Care plan – agreed action plan	Responsible person and signature	Due date	Updates
	Signature:	DD / MM / YYYY	
	Signature:	DD / MM / YYYY	
	Signature:	DD / MM / YYYY	
	Signature:	DD / MM / YYYY	
	Signature:	DD / MM / YYYY	

Details of anyone who disagrees with parts of the plan and why:

### GUIDANCE FOR COMPLETING FORM CM3A: CHILDREN IN CONFLICT WITH THE LAW

This form is only completed for children in conflict with the law. Interview the child about his/her history in conflict with the law, and get the child's perspective on the current offence, the motivation and the likely consequences of the offence. It is also important to ask the child what could have prevented him/her from committing the offence.



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## CM 3a: Specialization – Child in conflict with the law

To only be completed for child justice cases

Part 1: Client Information			
Client's surname:	First names:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	MGECW ref #:
Part 2: Criminal history			
Have you been arrested before? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes; elaborate:			
Previous convictions:			
Type of diversion programme attended and outcome:			
Do you have any pending cases and what is the charge?			
Part 3: Current offense			
Current offense as narrated by the child offender:			
Actions and intentions that led to the offense (motivation)?			

**C M 3a: Specialization – Child in conflict with the law**

*To only be completed for child justice cases*

Client surname / first name:

MGECW Ref #:

Outcomes and consequences as described by the child offender *(for the offender, victim, the family and community)*

Reasons and motives *(include the external events or circumstances which act as triggers for an offence and internal and personal e.g. attitudes, beliefs and desires)*

Patterns of offending behaviour *(Consider any similarities or differences between current and previous offences and, in particular, whether there is any evidence of increasing frequency or seriousness of offending behaviour)*

What support would you have needed to prevent you from committing the crime?

**Part 4: Other relevant information**

Any additional information you would like to share?

**Note any plans to talk to respondent / complainant** *(if so, please complete respondent page):*

## STEP 4: COURT REPORT

### WHAT IS THE PURPOSE OF THIS STEP?

The court report is the instrument used to effect child protection order as required by CCPA. It is a legal and formal record, completed in a prescribed format, and is used by a social worker in cases where the risk assessment has indicated that the child is exposed to a high level of risk and therefore needs protection. It is a professional summary, from social worker to magistrate, of the current situation of the child and includes a recommendation for action.

### IS THIS MANDATORY?

**Form CM4: Court Report** must be written when a social worker recommends a child to be removed and placed in alternative care or to remain at home with a protective care plan, and in all cases of children in conflict with the law. If the case goes to court, the social worker **MUST** produce a detailed court report with clear reasons for recommendations within 45 days of receiving the referral, or 30 days if the child has been removed from the home (CCPA 134, 3).

### WHAT IS THE OUTCOME?

The outcome is a decision by the court on whether the social worker's prevention and early intervention recommendation holds, and has the power to oblige the child or family to undertake the prevention or early intervention actions.

## GUIDANCE FOR COMPLETING FORM CM4: COURT REPORT

**The court report must be typed. The form is provided to each office in electronic format, which can be typed into directly.**

The content of Form CM4 is developed from the information gathered from CM1 and CM2, and provides an analytical summary of the findings of the social investigation (Form CM3), together with the key factors and a clear case for the recommendations to the children's commissioner. The report does NOT require any additional investigation or interviews.

Should the social worker determine that the child is not in need of protective services, the Children's Commissioner must be informed as to what assistance and measures will be made to assist the family. These interventions may include: counselling; mediation; early intervention programs; family reconstruction; behaviour modification; rehabilitation services, etc., or referral to another suitably qualified person. The recommendation is made then through a court child protection hearing, which must be called within 30 days of completion of the social investigation.

### GUIDANCE ON INDIVIDUAL SECTIONS:

#### 1 | INTRODUCTION AND PURPOSE:

This should state that the report is a recommendation from a social worker following referral of a child in need of protective services and should include a concise summary of the key reasons for the initial report (can usually be taken from Form CM2).

## 2 | FAMILY COMPOSITION:

A brief factual summary including who the child lives with, where parents are if not with child, and who lives in the child's household.

## 3 | SOURCES OF INFORMATION:

A list of the people involved in case conferences and social investigation who have provided the information contained in the report.

## 4 | SECTIONS E TO G:

A synthesis of the key findings of Parts 1-3 of the social report, highlighting the most relevant factors that have informed the social worker's recommendation in the report.

## 5 | CHILD CONCERNED:

Note any key documents, such as birth certificate, and any significant gaps or records that the court should be aware of, such as previous child justice processes.

## 6 | VIEWS OF THE CHILD CONCERNED:

A concise summary of what the child wishes and how the child feels that this can best be achieved. The final court decision must ensure the best interests of the child, so this section must demonstrate the child's perceived risks and resilience, as well as any important factors that will have an impact on this.

## 7 | MEASURES TO ASSIST FAMILY:

A summary of all actions documented in the care plan and case conference records.

## 8 | PRIVATE FAMILY ARRANGEMENTS:

Note any informal caring arrangements; note N/A if not applicable.

## 9 | EVALUATION:

This is a summary of the above sections, and should be a concise summary of the reasons that have led to the following recommendations. Use theories of social work to strengthen the recommendations.

## 10 | CONCLUSION:

This should be a very concise summary of what is to be expected from the recommendations that are in the child's best interests.

Mark all recommended measures for both child and family, and provide details of recommended duration and expected goals. These can be taken from **Form CM3, Part 4: Care Plan**.



### CM 4: Court Report

File no. \_\_\_\_\_ Court file no. \_\_\_\_\_

<b>Professional Report By</b>	
Full names: _____	
Signature: _____	Registration no: _____
Qualifications: _____	
Registered social worker address: _____ _____	
Tel. no: _____	Date: DD / MM / YYYY
Nature of report: _____	
Supervisor's name / signature: _____	Date: DD / MM / YYYY

**A. Introduction and purpose** (Nature of report; outline of what report attempts to achieve. Factors resulting in investigation, including events leading to investigation (complete chain of events and discuss factors listed in section 139 of the CCPA)

**B. Identifying details of child / children forming subject of report**

Full name(s)	Sex	DOB / estimated age / identity number
	<input type="checkbox"/> M <input type="checkbox"/> F	
	<input type="checkbox"/> M <input type="checkbox"/> F	
	<input type="checkbox"/> M <input type="checkbox"/> F	
	<input type="checkbox"/> M <input type="checkbox"/> F	
	<input type="checkbox"/> M <input type="checkbox"/> F	
	<input type="checkbox"/> M <input type="checkbox"/> F	
	<input type="checkbox"/> M <input type="checkbox"/> F	



## CM 4: Court Report

Residential address: \_\_\_\_\_

\_\_\_\_\_

Home Language: \_\_\_\_\_

Religious affiliation (if applicable): \_\_\_\_\_

Present caregiver name: \_\_\_\_\_

Present caregiver address: \_\_\_\_\_

\_\_\_\_\_

### C. Family Composition

**D. Sources of information** (persons from whom information had been obtained to compile report – indicate names, addresses, contact numbers and relationship to the child / children)

**E. Family profile** (summary of family background and dynamics, including parent / guardian / caregiver health and wellbeing, presence and role of extended family in relation to children forming subject of report, noting the potential for support and potential risks and impact on the child)

**F. Child's relationships with significant others** (summary of the relationships between child and family members / care providers for child in alternative care, and extent to which this affects child's access to constant care and support and child's safety, child's interactions with peers and others in community and any special circumstances that affect child's need for protection and care)

**G. Community and environmental impact on child's wellbeing and safety** (summary of child's physical safety and security in relation to housing and environment, child's interaction with and access to social, religious and cultural sources of support and any potential risks related with these, extent to which child is socially accepted and supported, directly and through family)



## CM 4: Court Report

- H. Aspects of the child / children concerned** *(Any relevant supporting documents to be attached as annexure such as birth certificate, education records, health records)*

- I. Views of the child / children concerned** *(Reflect emotions, feelings, preferences, personal needs and any other relevant observations by child / children)*

- J. Previous interventions** *(previous decisions or inquiries in respect of child/children to be indicated, whether child had been removed to temporary safe care; family preservation services rendered or attempted; whether child had been a victim of trafficking and returned to or found in the Republic)*

- K. Evidence and facts** *(allegations of abuse / neglect; incidents; claims – affidavits and any other supporting documents to be attached as annexure):*

- L. Medical evidence** *(In cases of assault or abuse; any supporting documents to be attached as annexure):*



### CM 4: Court Report

**M. Measures to assist the family** Steps take to improve family situation (*counselling, mediation, prevention and early intervention services family reconstruction and rehabilitation, behaviour modification, problem solving, referral*):

**N. Evaluation** (*Positive and negative factors, causes and results*)

**O. Recommendation** (*Indicate which order or orders in terms of section 42 (2) and s47 (2)(a-h)(3). Motivate the recommendation and include recommendation on duration of order and level of supervision required, if applicable*)

**P. Recommend measures to assist child’s family** (*Mark with an “X” and substantiate*)

Measure(s) – mark with an X	Further detail and substantiation
<input type="checkbox"/> <i>Counselling</i>	
<input type="checkbox"/> <i>Mediation</i>	
<input type="checkbox"/> <i>Prevention and early intervention services</i>	
<input type="checkbox"/> <i>Family reconstruction and rehabilitation</i>	
<input type="checkbox"/> <i>Behaviour modification</i>	
<input type="checkbox"/> <i>Problem solving</i>	
<input type="checkbox"/> <i>Referral to another suitably qualified person or organisation</i>	
<input type="checkbox"/> <i>Other</i>	



### CM 4: Court Report

**Q. Recommended measures to assist child** (Mark with an 'x' and substitute)

Measure(s) – mark with an X	Further detail and substantiation
<input type="checkbox"/> <i>Therapeutic</i>	
<input type="checkbox"/> <i>Educational</i>	
<input type="checkbox"/> <i>Cultural</i>	
<input type="checkbox"/> <i>Linguistic</i>	
<input type="checkbox"/> <i>Developmental (attach separate forms as Annexure if required)</i>	
<input type="checkbox"/> <i>Socio-economic</i>	
<input type="checkbox"/> <i>Spiritual</i>	
<input type="checkbox"/> <i>Other</i>	

**R. Reunification services** (the social worker must briefly outline whether reunification services are advised or not. If the social worker assessment is that reunification will not be favourable for the child, the social worker must indicate the proposed permanency plan for the child, post the two year alternative care placement.)

Report compiled by: \_\_\_\_\_ Title / Rank: \_\_\_\_\_

Social worker signature: \_\_\_\_\_ Date: \_\_\_\_\_

Supervisor's name: \_\_\_\_\_ Title / Rank: \_\_\_\_\_

Supervisor signature: \_\_\_\_\_ Date: \_\_\_\_\_

Official date stamp

## STEPS 5-7: FOLLOW-UP AND CASE REVIEW WITH ONGOING CASE MANAGEMENT AND SUPPORT, INCLUDING REFERRAL AND CASE CONFERENCING

### WHAT IS THE PURPOSE OF THESE STEPS?

These steps can be used at any time during the case management process, and can be repeated as needed. After the plan is made and approved by all, the social worker will continue to **directly support the child and/or supervise other actions** recommended in the care plan through follow-up. Each time contact is made with the child or others involved in the case, this should be documented on **Form CM7: Follow-up and Case Review**. The frequency of formal review of progress will vary case by case, but all cases should be reviewed at a minimum of once every three months.

### REFERRALS AND CASE CONFERENCING CONDUCTED ACROSS THE CASE MANAGEMENT PROCESS

**Referral of a client for services (Form CM5)** solicits the specialised assistance of another service provider who can complement the support provided by the social worker. A number of different referrals may be made for a single client according to different needs identified in the care plan.

**A case conference (Form CM6)** can take place at any point in the case management process, and is a formal multi-sector / inter-organisational case planning or review of a case. The purpose is to review interventions and make formal decisions in the best interests of the child. The meeting is arranged by the social worker, and attended by other service providers involved in the case and, as appropriate, the child, his or her parent / guardian / caregiver and other important family members, as well as others who can offer protective care and support. The case conference is a forum to share information, identify the strengths and challenges that the child and family face, and agree on a plan of action to build on strengths and support the child. In addition to the case conference, the social worker may continue to hold separate meetings with the child and family, sometimes referred to as a family group conference. Such meetings can also aid in ensuring that the appropriate interventions are in the best interests of the child.

### IS THIS MANDATORY?

Follow-up and case review are not set out in the CCPA, but it is essential for good case management to have regular follow-up visits to assess whether the child and/or family concerned have received the appropriate services, the necessary support, and, through these services, have been assisted. Follow-up and case review are also an opportunity to assess progress in relation to the goals set in the care plan. In case of court hearings, the social worker must submit a plan with an end date and inform the court. A case closure process would comply with this recommendation.

### GUIDANCE FOR COMPLETING FORM CM 5: BI-DIRECTIONAL REFERRAL OF A CLIENT FOR SERVICES

**Form CM5** can be completed at any point in the case management process from initial intake to case closure. **Form CM5** is to be used **alongside ongoing interventions by the social worker**. Referring is not care planning or case closure (use **Forms CM3, Part 4 and CM 8**).

It is used to make a **contact** with a service provider to request, on behalf of the client, that specific services are provided to the child/family. These may be specialist services. Ongoing engagement in case management would be addressed through the case management process.

**NOTE:** Children in conflict with the law referrals have their own forms.

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Referrals might include (all services articulated in Namibia's referral system; this list is not exhaustive):

- *Criminal investigations conducted by police*
- *Health services (medical examination, treatment, emergency drugs) provided by health workers and health centres*
- *HIV prevention, testing and counselling, and treatment and care services provided by HIV clinics*
- *Counselling services provided by LifeLine/ChildLine, Philippi Trust Namibia, private practitioners, church leaders*
- *Education support*
- *Disability support*
- *Drugs and alcohol support*
- *Legal services*
- *Civil registration (births and deaths from MHA)*
- *Grants (MGECW)*
- *Aftercare (community support, rehabilitation, reconstruction, after-trial services)*

**GUIDANCE ON SPECIFIC SECTIONS:**

**PART 1 | REFERRAL OUT**

1. Provide all available details that are specifically relevant for the referral that is made, without providing confidential information that is not necessary for the referral organisation to take appropriate action.
2. Summary of problems: focus on the aspects of specific relevance to the referral organisation without breaching any unnecessary confidentiality. For example, if a grant application is being made, it is not necessary to provide details regarding the educational challenges faced by the child.
3. Reasons for referral/recommendations or expected results: complete in relation to the protection elements that have been identified. The social worker is not expected to make a detailed analysis of the proposed actions from the referral organisation; the social worker does not have to provide expected health outcomes, but may say that an expected result is that the child receives counselling and support on sexual and reproductive health-related issues, if that is part of the protection issue.

Keep one copy of the form in the case file, give one copy to the child or caregiver, and send one copy to the referring organisation.

Keep a record of when to follow up when a reply has not been received.

**PART 2: RECEIPT OF CLIENT REFERRAL FOR SERVICES**

The person or organisation to whom the referral is made reports back on the outcomes of the referral by completing the receipt part of the form.



**CM 5: Bi-directional referral of a client for services | Part 1**

Please complete page 1 for any child or adult needing mandatory or non-mandatory social services

Details of organisations' referred to:

Date: DD / MM / YYYY

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**Dear Colleague,**

The client listed below has been a client of this Ministry/ organisation, and needs additional services. I am thus referring him / her / family to your organisation for the necessary services or assistance based on the background information provided below. Please complete the attached feedback page and return it to me. Please contact me if you have any issues.

Client's surname:	First name:	Date of birth: DD / MM / YYYY	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Tel/Cell:	Contact of Client's Details (Physical Address):		
Best way to reach client / family:	<b>Contact details of child's parent / guardian / caregiver if a minor</b> Name: _____ Tel/Cell: _____ Address: <input type="checkbox"/> Same as Above <input type="checkbox"/> Different:		

Details of the additional clients (adult / children concerned):

Surname	First name	Date of birth	Sex
		DD / MM / YYYY	<input type="checkbox"/> Male <input type="checkbox"/> Female
		DD / MM / YYYY	<input type="checkbox"/> Male <input type="checkbox"/> Female
		DD / MM / YYYY	<input type="checkbox"/> Male <input type="checkbox"/> Female
		DD / MM / YYYY	<input type="checkbox"/> Male <input type="checkbox"/> Female
		DD / MM / YYYY	<input type="checkbox"/> Male <input type="checkbox"/> Female
		DD / MM / YYYY	<input type="checkbox"/> Male <input type="checkbox"/> Female

Summary of problems / issues:

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Client surname / first name:

MGECW Ref #:

Reasons for referral / recommendations or expected results:

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These have been identified and discussed with client:  Yes  No

Other information that may be helpful to this referral:

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**MGECW services will:**

- Remain open to complement your services*  *Close upon transfer of case to you*

**Documents accompanying this referral form:**

- Psychosocial report*  *School report:*  *Medical report*  
 *Birth certificate*  *Death certificate*  *Other:*

**CONTACT DETAILS OF PERSON REFERRING:**

---

Name: \_\_\_\_\_

Contact details: \_\_\_\_\_

Signature: \_\_\_\_\_

Official date stamp

Referring organisations details:



Ministry of Gender Equality and Child Welfare

**CM 5: Bi-directional referral of a client for services | Part 2: Receipt of client referral**

**Date:** DD / MM / YYYY

**Contact details / address of the person who made the referral:**

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**Dear Sir, Madam, Colleague,**

I \_\_\_\_\_ (service provider receiving referral) \_\_\_\_\_, hereby acknowledge the receipt of the referral for \_\_\_\_\_ (client's name) \_\_\_\_\_, case number: \_\_\_\_\_ (if known) \_\_\_\_\_ for follow up services. We thank you for bringing this client to our attention.

**We have reviewed the report and would like to inform you that the following actions will be undertaken:**

Case is receiving attention and further investigations are being made: \_\_\_\_\_

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We are able to, or have provided requested services: \_\_\_\_\_

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Did not provide requested services because (explain in brief): \_\_\_\_\_

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We value your interest in this client and sincerely appreciate your contribution to improving the lives of others.

Yours sincerely,

\_\_\_\_\_  
Name of Staff / agency

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Official Date stamp

Telephone number:

## GUIDANCE FOR COMPLETING FORM CM6: CASE CONFERENCE RECORD

*Please see also Job Aid 13: Guide to case conferencing*

A case conference is usually necessary to develop the care plan, even if there has not been a prior case conference. Case conferences should be regularly conducted and documented. Not all case conferences will need to be attended by all actors; the social worker, as case manager, will decide who should be present at each. The child/family will attend as appropriate, and if not present, should be informed of the case conference, the discussions held, and decisions made. Case conferences are documented using **Form CM6: Case Conference Record**.

When deciding to conduct a case conference, the social worker must provide clear guidance as to when, what and why a case conference must be held, who should be involved, and how the minutes of the conference must be recorded.

The ensuing report captures the details of the participants, discussion points and key outcomes of an agreed-upon joint meeting to discuss a case. Such a meeting may be held at any point in the case management process, and is designed to harness and benefit from collective support, guidance and information.



## CM 6: Case Conferencing

Client's Surname:	First name:	Date of birth: DD / MM / YYYY	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Date of case conference: DD / MM / YYYY		Type of case conference: <input type="checkbox"/> Scheduled <input type="checkbox"/> Unplanned	
Location of case conference: <input type="checkbox"/> Child's home <input type="checkbox"/> Office <input type="checkbox"/> Other:			
Aim of case conference (e.g. during assessment, routine monitoring, support):			
Names of all family participants (including children):			
Names & agencies of all non-family participants:			
Key discussion points:			
Key outcomes of meeting:			

Client surname / first name:

MGECW Ref #:

Any observation on dynamics of meeting:

If the client is a child, did you have the opportunity to speak with the child whose case it is individually?  Yes  No

If yes, what was the outcome of the discussion? If not, note date for follow up visit to child.

Next case conference or social worker follow up:

Date: DD / MM / YYYY

Type, location, purpose / aim:

Signature of social worker: \_\_\_\_\_

Date: DD / MM / YYYY

I, \_\_\_\_\_ (Client's name and / or parent / guardian / caregiver, as appropriate)  
have read / been told the key decisions made at this meeting:

Signature: \_\_\_\_\_

Date: DD / MM / YYYY

Supervisor Recommendations:

Report reviewed and approved by: \_\_\_\_\_ (Supervisor signature)

Date: DD / MM / YYYY

## GUIDANCE FOR COMPLETING FORM CM7: FOLLOW-UP AND CASE REVIEW

This document is to be completed every time there is a call or visit relating to the case, for the purposes of keeping a record of all contacts and events.

Page 1 notes the type and location of the follow-up, its aim and who was interviewed. The evaluation box at the bottom of the page should identify any major changes noted since the last visit that will affect the time frame or expected outcomes of the care plan (**Form CM 3 part 4**).

Progress on each action identified during the care plan or previous follow-up visit should be tracked on the second page of the form.

For each review, the social worker will gather all the information about progress towards achieving all the proposed goals so that child, family and all stakeholders can measure whether goals have been met or not. The social worker will ask all the relevant actors to attend, and it is essential that the child and other significant family members, when necessary, are at the meeting.

At the review, if it is clear that the child is no longer in need of protective services, the case can be closed. If more support is needed, the care plan is updated, and ongoing support is provided until the date of a next proposed review. If the child or family refuse to follow the recommended actions in the care plan and fail to cooperate with the social worker, the case can be taken back to court. The family and/or the child can be ordered to cooperate, if the child is younger than 18 years.





Ministry of Gender Equality and Child Welfare

## CM 7: Follow up and case review | Part 2: Case review

Client's surname:	First name:	Date of birth: DD / MM / YYYY	MGECW Ref no:
Social worker:		Date of interview: DD / MM / YYYY	
Combined with case conference and/or care plan: <i>(If yes, attach)</i> <input type="checkbox"/> Yes <input type="checkbox"/> No		Reason for follow up: <input type="checkbox"/> Statutory <input type="checkbox"/> Non-statutory	
Location of review: <input type="checkbox"/> Client's home <input type="checkbox"/> Office <input type="checkbox"/> Telephone <input type="checkbox"/> Other:			
Aim of review <i>(e.g. assessment, routine monitoring, support)</i> :			
Court ordered provisions <i>(if applicable)</i> :			
Person(s) interviewed with notes:			
Level of current risk <i>(low/medium/high)</i> with notes:			
Please note any major changes in any information and /or actions on the client and family:			
Recommendations:			
Social worker signature:		Date: DD / MM / YYYY	
Supervisor signature:		Date: DD / MM / YYYY	

## STEP 8: CASE CLOSURE

### WHAT IS THE PURPOSE OF THIS STEP?

**Case closure (CM8)** will happen if all of the goals of the care plan have been reached, or most of them, with it being clear that the child or family can meet the outstanding goals without further monitoring and follow-up visits. The social worker must ensure that the child is safe from harm, his or her care and well-being are being supported, and there are no additional concerns before this step is taken.

A social worker can also close the case in relation to his or her workload if the child has moved away, and the closure in this case requires informing the social work counterpart in the district to which the child has moved. If such a child has been found to be in need of protective services, and a court order has been issued for such protective services, the child must be referred to the regional MGECW or a designated child protection organisation for continued services until such time that the child is no longer considered to be in need of protective services as defined within the CCPA.

In some cases, if the child refuses to cooperate and reaches the age of 18, the case may have to be closed without reaching goals, but can be referred to social services at MOHSS for ongoing adult care and support. This should only happen on very rare occasions.

Case management requires that the case manager is supported by the supervisor to ensure that cases are not prematurely closed.

### IS THIS MANDATORY?

Case closure is not mandatory, other than when a plan has been submitted through a child protection hearing. However, it is good practice in case management.

If a child who has been through the statutory process moves away from the area where the initial court process was conducted, then the transfer is a mandatory process. The court must be made aware if the child is taken out of its area of jurisdiction, and the court and local MGECW office where the child now resides is made aware of the transfer as outlined in **s41 (3); and s82 of CCPA**.

### WHAT IS THE OUTCOME?

When the child no longer faces protection risks and/or the child is getting adequate support to meet the needs elsewhere, with the result that the child no longer requires MGECW case management services, the social worker closes the case.

If, at a later point, an additional need presents, the client can return and the case can be reopened. If a child's case is reopened, the original case number is used and the case file is reopened (rather than opening a new case number) in order to have a comprehensive history to inform care plans.

### GUIDANCE FOR COMPLETING FORM CM8: CASE CLOSURE

Prior to the proposed end of the case as identified in **Form CM3, Part 4** and updated over time, the social worker should call for a review.

A review is a more detailed assessment of whether the planned goals have been reached, and, if so, whether the child is now safe. Once completed, the case is closed.

**GUIDELINES ON SPECIFIC SECTIONS:**

1. Decision taken for case closure: tick one of the four boxes only.
2. Summary of reasons for case closure: provide a rapid summary, including evidence of why the decision has been taken. Reference can be made to progress reports or case conference notes. Provide supporting documentation where relevant and note any action resulting from the decision, for example, a final referral to another party or court processes that close the case.
3. People involved: if key people are not present, ensure that they have had input prior to the meeting so that their perspectives are taken into consideration.
4. Child involvement: it is essential that the child is involved in the decision, where age- or developmental stage-appropriate.
5. Supervisor should be involved in the final decision before closure and must sign off on the form.



Client surname / first name:

MGECW Ref #:

Client and/or child's parent / guardian / caregiver (if applicable) know where to go and who to reach in case of further problems:

Yes  No

Discussed and agreed upon follow up actions if ever need be:

Any additional information

I, \_\_\_\_\_  
(client and/or name of child or parent/guardian/caregiver, as appropriate) have read / been told the key decisions made at this meeting:

Client and/or guardian signature: \_\_\_\_\_

Date: DD / MM / YYYY

Social worker signature: \_\_\_\_\_

Date: DD / MM / YYYY

Supervisor signature: \_\_\_\_\_

Date: DD / MM / YYYY

Official date stamp

Post closure updates / actions / supports (if applicable):

Social worker signature:

Date: DD / MM / YYYY

Post closure updates / actions / supports (if applicable):

Social worker signature:

Date: DD / MM / YYYY

Post closure updates / actions / supports (if applicable):

Social worker signature:

Date: DD / MM / YYYY

## CM9: CASE-TRACKING CHECKLIST

### WHAT IS THE PURPOSE OF THE CASE TRACKING CHECKLIST AND SUPERVISION LOG?

The case tracking checklist is used by the social worker to keep track of a client throughout the case management process. The checklist must also be used by the supervisor to ensure case management processes are taking place as required, and to provide supportive supervision.

#### GUIDANCE FOR COMPLETING FORM CM9: CASE-TRACKING CHECKLIST

The checklist should be placed at the top of the case file (possibly on the left-hand side) for easy access. The goal is to ensure that the case is being followed through the case management process, while tracking the overall progress of a case. The social worker allocated to the case **must** complete the form to indicate progress with the case.

The checklist is to be completed by MGE CW for **each individual case**.

- *Part 1 enables tracking of important dates and processes.*
- *Part 2 is for the supervisor to write brief notes after each review of the tracking checklist.*





MGECW Ref #:

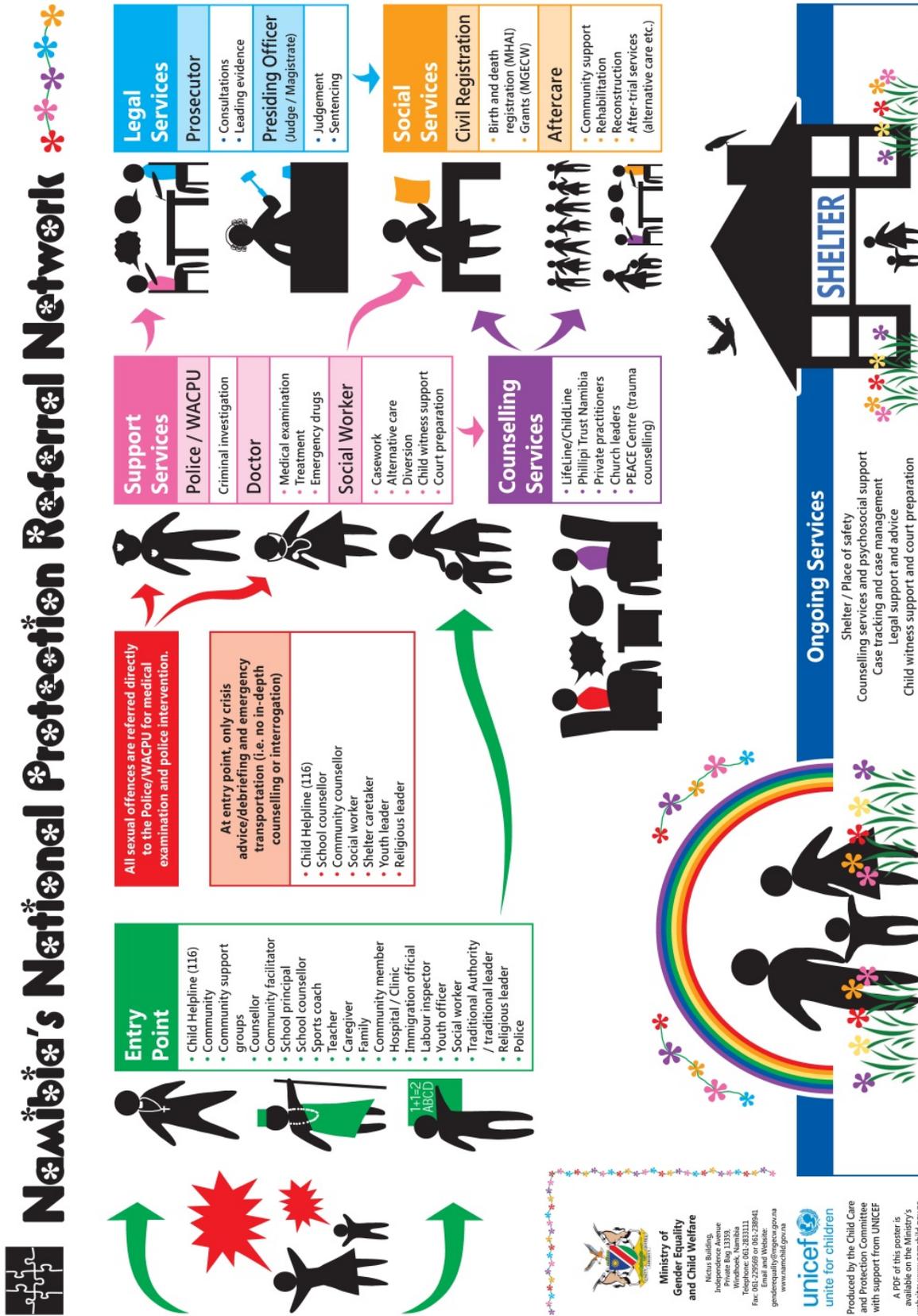
Client's surname:	First name(s):	Date of birth: DD / MM / YYYY
<b>Case review and social worker plan of action (Why/Where/When/What/Whom):</b> <i>Five pages for each CM9</i>		
<b>Supervision review date:</b> DD / MM / YYYY <b>Needs and other actions identified:</b>		
<b>Supervision review date:</b> DD / MM / YYYY <b>Needs and other actions identified:</b>		
<b>Supervision review date:</b> DD / MM / YYYY <b>Needs and other actions identified:</b>		



**PART 3 OF 3:**

Job aids for case management  
for children in need of  
protective services

# Job Aid 1 | Namibia's National Protection Referral Network flow chart\*



\* The chart is an illustration of the general overview of the flow of referrals; to be updated.

## Job Aid 2 | Child Care and Protection Act (CCPA) reporting requirements

### A. CCPA DEFINITIONS OF CHILDREN IN NEED OF PROTECTIVE SERVICES

#### **ARTICLE 131 (1): A CHILD IS IN NEED OF PROTECTIVE SERVICES, IF THAT CHILD:**

1. is abandoned or orphaned and has insufficient care or support;
2. is engaged in behaviour that is harmful or is likely to be harmful to the child or any other person, and the parent or guardian or the person with the care of the child is unable or unwilling to control that behaviour;
3. lives or works on the streets or begs for a living;
4. is being or is likely to be neglected, maltreated or physically or mentally abused;
5. is addicted to alcohol or another dependence-producing drug, and is without any support to obtain treatment for such dependency;
6. is below the age of 18 years and is involved in a criminal matter;
7. is an unaccompanied foreign child;
8. is chronically or terminally ill and lacks a suitable care-giver;
9. is being kept in premises which are extremely overcrowded, highly unsanitary or dangerous.

#### **ARTICLE 131 (2): A CHILD IN THE FOLLOWING CIRCUMSTANCES MAY BE A CHILD IN NEED OF PROTECTIVE SERVICES, AND MUST BE REFERRED TO A DESIGNATED SOCIAL WORKER FOR AN INVESTIGATION:**

- a child who is a victim of child labour;
- a child in a child-headed household;
- a child who is a victim of child trafficking;
- a child who lives in or is exposed to or is at risk of living in or being exposed to circumstances which may seriously harm the physical, mental, emotional or social well-being of the child;
- a child whose parent has been imprisoned and who lacks a suitable care-giver;
- a child below the age of 16 years who is found to be pregnant;
- a child who has been the victim of a serious crime against the child's person;
- a child who is engaged in commercial sex work or has been subjected to any form of sexual exploitation;
- a child living in a violent family environment, including a child named in a protection order issued under the Combating of Domestic Violence Act, 2003 (Act No. 4 of 2003);
- a child below the age of 16 years who is habitually absent from school;
- a child whose parent, guardian or caregiver unreasonably withholds consent to necessary medical intervention or therapeutic intervention;
- a child below the age of 16 with any sexually transmitted infection, or any child with multiple or repeated sexually transmitted infections;
- a child involved in a case referred for investigation by the Children's Advocate;
- a child reasonably suspected of falling under subsection 1.

## WHO MUST REPORT AND WHEN

- **Article 132 (1):** Anyone ‘who performs professional or official duties with respect to children’ and who hears about it during the course of his or her work, using a prescribed form (Form CM1) submitted to a state-employed social worker or a member of the police.
- **132. (2):** The categories include “a school principal, teacher, medical or dental practitioner, pharmacist, school counsellor, dentist, psychologist, psychological counsellor, nurse, physiotherapist, speech therapist, occupational therapist, traditional leader, traditional health practitioner, legal practitioner, religious leader, labour inspector, social worker in private practice or employed by a child protection organisation or a member of staff at a registered place of safety or a facility.
- **132. (3):** Anyone else, including another child, may report their concern to any state-employed social worker or a member of the police.

## KEY REPORTING ACTIONS AND TIME FRAMES FOR A CHILD IN NEED OF PROTECTIVE SERVICES

- **Article 134 (2):** Any social worker or member of the police who has received a report that a child may be in need of protective services must **make an initial assessment within 24 hours of receiving the report**. This may include seeking a warrant from a children’s commissioner to remove the child from his or her home or remove the alleged offender (except in cases where delay to removal would jeopardise the child’s safety and wellbeing, Article 136 (1), in which case the child can be removed without delay and the court receives a report on the next court day, or the alleged offender removed by written order, Article 137(1); **Form CM2: Intake and Rapid Risk Assessment**.
- **Article 134 (3):** If the report that a child may be in need of protective services goes to a member of the police or to a social worker who is not a designated social worker, that member of the police or social worker, in addition to conducting an initial assessment (Article 134[2]), must **submit the report to a designated social worker within 48 hours**, or on the first court day after the 48 hours expires; **Form CM2: Intake and Rapid Risk Assessment**.
- **Article 134 (3):** If a designated social worker receives a report that a child may be in need of protective services or if it comes to the attention of a designated social worker that a child may be in need of protective services, the social worker must without delay report the matter and report any steps already taken **to the Director responsible for child welfare services in the Ministry** and start an investigation.
- **Article 135 (5):** When a child or alleged offender has been removed from the home, under Article 134(2), the social worker **must inform the child’s parent or guardian and the person in whose care the child had been before the removal without delay but within 24 hours**, if they can be traced. They must also inform the clerk of the court that the removal has occurred on or before the next court day.
- **Article 138 (1):** When a child has been removed from the home, he or she must be **brought before a children’s court as soon as possible, and no later than five days after the removal**, to decide about placement of the child.
- **Article 139 (1):** A designated social worker who receives a report that a child may be in need of protective services must **investigate the child’s circumstances within 45 days if the child remains in the care of his or her parents or guardians and within 30 days when a child has been removed from the home and requires placement**. (If the designated social worker can show a good reason for requiring additional time, the children’s commissioner can extend this deadline; Article 139 [2]). **Form CM3: Social Investigation** and **Form CM3, Part 4: Care Plan**.
- **Article 140 (1-4):** If a child is deemed to not need further protective services, the social worker must submit the review to the children’s court, but can recommend that the child and/or family participate in specified prevention or early intervention programmes. The recommendation can be optional, or can require that the child and/or

family participate, depending on the assessment. If the recommendation is compulsory, this must be for no more than six months.

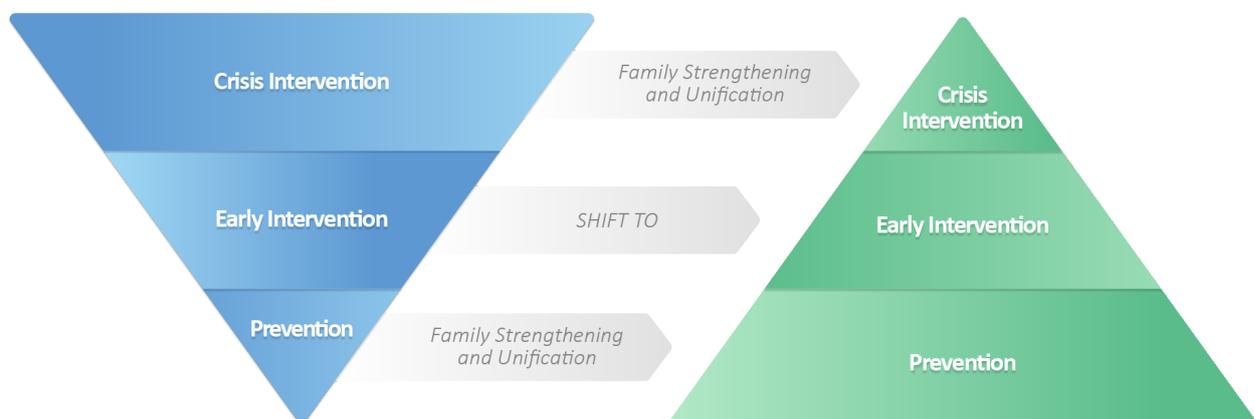
- **Articles 141 and 142:** Any recommendations in Articles 139 or 140 must be heard by a child protection hearing in court. The date must be fixed **no more than 30 days after the social investigation is submitted to court**, and the child protection hearing must be heard and determined within 60 days from the date on which it starts. The family must have at least 14 days' notice.

## PREVENTION AND EARLY INTERVENTION

According to the CCPA, prevention and early intervention programmes may include one or more of the following components:

- assisting families to obtain the basic necessities of life, including assisting with accessing grants or empowering them to obtain basic necessities of life for themselves and their children;
- providing families with information to enable them to access services;
- providing families with information about the dangers of alcohol and other drugs, and assisting them to address abuse of alcohol or drugs by any family member;
- providing families with information about gambling addiction, and assisting them to address such an addiction of any family member;
- supporting and assisting families with a chronically ill or terminally ill family member;
- assisting families to provide or access appropriate early childhood development opportunities for children who have not attained the school starting age;
- addressing specific issues affecting or potentially affecting families in the community, such as gender-based violence, health and nutrition issues, reproductive and sexual health issues, child labour, child trafficking or child behaviour problems;
- providing families with information regarding the resolution of disputes at a family meeting;
- promoting the well-being of children and the realisation of their full potential.

### *Shift in provision of services and levels of intervention*



*Adapted from The Thogomelo Project (2016), Induction Manual for Child Protection Social Workers.*

## CHILD CARE AND PROTECTION ACT SUMMARY OF IMPORTANT TIME FRAMES FOR CHILDREN IN NEED OF PROTECTIVE SERVICES

### ► *Intake & Initial Risk Assessment*

Within <b>24 hours</b> of receiving the report	<b>Form CM1:</b> Mandatory reporting  <b>Form CM2:</b> Intake and Risk Assessment	<b>Article 134 (2)</b>
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### ► *Notification To Designated Social Worker*

Within <b>48 hours</b> of receiving the report	<b>Form CM1:</b> Mandatory reporting  <b>Form CM2:</b> Intake and Risk Assessment	<b>Article 134 (3)</b>
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### ► *Removed Child Brought To Children's Court*

As soon as possible and no later than <b>5 days</b> after removal	<b>Article 138 (1)</b>
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### ► *Social Investigation*

Within <b>45 days</b> of receipt of report, or <b>30 days</b> if child has been removed from home	<b>Form CM3:</b> Social Investigation and Care Plan (CM3 Part 4)	<b>Article 139 (1)</b>
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### ► *Child Protection Hearing (for Child Recommended to Stay at Home)*

Date fixed within no more than <b>30 days</b> after the social investigation is submitted to the report, hearing heard within <b>60 days</b> of the court	<b>Article 141 and 142</b>
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## Job Aid 3 | Theoretical frameworks and approaches that inform the response to child protection and early intervention services

Theories and models help us to frame our thinking and interpret findings when investigating the nature and prevalence of a problem, its causes or its consequences. Theories and models help us to understand the developmental stage of a child, plan and review the manner in which we analyse, understand and therefore decide on which intervention to choose when protecting children<sup>12</sup>.

A number of these theoretical and conceptual frameworks that inform our thinking about the structure of the service system and the delivery of services to vulnerable families exist. However, we will concentrate on five which we think are most critical for child protection services. These are 1) The Child Development Theory; 2) The Systems Approach to Child Development; 3) The Theory of Risk and Resilience; 4) The Social Development Approach; 5) The Social Ecology Model.

### 1 | THE CHILD DEVELOPMENT THEORY

This theory is premised on the belief that children's emotional, physical and cognitive development occurs in consecutive stages. Each stage builds from the previous stage, and a child's progress through the stages is influenced by what was achieved or not achieved in the previous stages. Children are expected to respond in the same manner, at the same stage, and any deviations are viewed as 'abnormal' due to psychological or developmental impairments. This view has been regarded as very simplistic, because it does not acknowledge children's individual variations or their social and cultural diversities or the effects of their socio-economic contexts.

A number of historical and cultural views of childhood exist. For example, children may be viewed as decision makers, actors in their own social development and in their family contexts, their politics and/or sexuality. As a result, there is no single theory or view of childhood or adolescence because of the diverse nature and contexts within which children develop. Understanding child development has been greatly influenced by other theorists such as Lev Vygotsky<sup>13</sup>, who argued that children's minds are developed as they gather 'signs' and other tools, such as language, counting and writing, which are passed down from one generation to the next within a particular culture. Therefore, the traditional way of thinking of child development as a single road running from low to high levels of competence fails to take into account the fact that 'developing human beings change not only in respect to what they know they can do, but also and most importantly with respect to what their society permits them to do, that is what they may do'. This theory supports the view that children in different contexts have different abilities and competencies. However, contexts are not seen as static. They are negotiated constantly, renegotiated by participants, and are therefore 'dynamic'. Children, therefore, are growing and developing in dynamic social contexts.

### 2 | THE SYSTEMS APPROACH TO CHILD DEVELOPMENT

This relates to the ecological system theory, which states that the child is embedded in a dynamic system consisting of several environments that interact with one another<sup>14</sup>. At the centre of the ecological systems theory are the everyday interactions between children, significant people, objects and symbols. These 'engines of development' include parent-child or child-child interaction, play, reading, etc<sup>15</sup>. The personal characteristics of individuals

<sup>12</sup> Scott, Dorothy (2006). Towards a Public Health Model of Child Protection in Australia, Communities, Children and Families Australia: <https://search.informit.com.au/documentSummary;dn=368143967142546;res=ielhss>

<sup>13</sup> Vygotsky, Lev. Social Development Theory: Overview: <http://www.instructionaldesign.org/theories/social-development.html>

<sup>14</sup> Bronfenbrenner, Urie (1994). Ecological Models of Human Development, International Encyclopaedia of Education, Vol. 3, 2nd Edition; available online at: <http://www.psy.cmu.edu/~sieglar/35bronfenbrenner94.pdf>

<sup>15</sup> Ibid.

participating in these everyday activities influence what activities the child engages in. Children’s developmentally instinctive characteristics and adults’ beliefs in guiding or directing children include the personal values and beliefs of the individuals involved, which help determine what activities are encouraged and what competencies children will have in their context at a specific age, gender or growth stage.

The ecological system therefore consists of interrelationships between two or more micro-systems, such as the relationship of the family to the school or the family to the children’s peers. In addition, it involves the child in social settings that exert an indirect influence on the individual’s development, such as a parent’s employment experiences. The macrosystem involves groups whose members share value or belief systems, ‘resources, hazards, lifestyles, opportunity structures, life course options and patterns of social interchange’<sup>16</sup>. In other words, it refers to the attitudes or ideologies of the culture in which individuals live. Furthermore, the entire system has to take into account the time, e.g., the transitions over an individual’s lifespan and the socio-historical setting.

However, because children are individuals and have their own characteristics, children actively change these environments in their daily practice and everyday interactions. These environments include interpersonal relationships, value or belief systems, economic and social settings, all of which change over time. Ecological perspectives such as these have been criticised on several grounds, including the difficulty of defining the levels with precision, and describing the interaction between factors at different levels.

Nevertheless, by embedding individual action and decision-making within contexts of interpersonal relationships, which are in turn embedded within dynamic socio-cultural and economic systems, this model forms a useful basis for understanding the complexity of children’s development.

The social ecology model is gaining ground once again in terms of child protection. It is multi-dimensional, and therefore leads to the management of issues at all spheres of the child’s life. Its application can result in both safeguarding and reducing the occurrence of abuse. Most negative circumstances that children need protection from are the result of a number of factors, such as child’s relationship with a parent, family members or friends, and this is influenced by what occurs in a community and the society at large. This social ecology approach is a systems approach to child protection, as it will allow one to see the child within his or her environment, and will therefore ensure that any intervention will reduce the risks and vulnerability, and strengthen protective factors<sup>17</sup>.

An ecological systems theory of development and child protection views the child as an individual living within the context of his or her relationship with others and their socio-economic and cultural circumstances.

### 3 | THE THEORY OF RISK AND RESILIENCY

This approach is essential for understanding how adversity may affect children’s development and ability to cope or survive in the face of adversity. Risk and resiliency are therefore explored in relation to the emerging systems approach<sup>18</sup>.

Risk refers to factors that may or may not be obvious, and that create potential harm or danger for children or increase the vulnerability of children. Vulnerability means that children are unprotected from possible danger or harm, or that they are unable to protect themselves. ‘Children at risk’ are children who are exposed to risk factors that could put them in danger or harm, and who are unable to protect themselves.

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<sup>16</sup> Ibid.

<sup>17</sup> Ibid.

<sup>18</sup> Corcoran, Jaqueline and Ann Nichols-Casebolt (2004). Risk and Resilience Ecological Framework for Assessment and Goal Formulation, Child and Adolescent Social Work Journal, Vol. 21, No. 3: <https://pdfs.semanticscholar.org/7ff0/8c7a1db2c1157d2b500e02717852a1f3257d.pdf>

A vulnerable child, or 'child at risk,' is therefore understood as a child whose survival, care, protection or development may be compromised due to particular conditions, situations or circumstances that prevent the fulfilment of his or her rights. By understanding the contexts that create risk or danger for children, prevention and intervention services are better able to target actions and responses to those dangers – prior to the child or family requiring statutory or therapeutic intervention.

In spite of the many risk factors to which children are exposed, and that children are becoming increasingly vulnerable in the context of HIV and AIDS, each child has his or her own strengths, characteristics or coping mechanisms that may help protect him or her from harm, danger or abuse. This resilience is informed by a complex interaction of factors at the macro, interpersonal and individual levels. For instance, it has been found that one factor helping children manage the effects of adversity is commitment to ideology (such as faith, a philosophy or psychological outlook). This provides a child with an explanation for why hardships occur. At the interpersonal level, a child's community, which widely includes relatives, teachers and other familiar adults and children, plays an important role in helping a child to cope with adversity.

Some children rely on their peers for support. At the individual level, resources that influence resilience include individual characteristics, such as physical appearance, emotional well-being, self-esteem and self-efficacy. Children's individual coping mechanisms include good social skills, inter-personal sensitivity, self-control, cognitive competence (an average level of intelligence) and self-confidence.

However, it is important to note that resilience is as much about the individual child's personal qualities as it is about the child's context. The greater the support, care and safety of the child's environment, the easier it is likely to be for the child to navigate and negotiate tensions or life situations. There are seven resilience tensions that need to be navigated and negotiated: relationships, cultural adherence, cohesion, access to material resources, social justice, power and control, and identity. Research suggests that when a child feels overwhelmed by the risk factors and does not feel able to cope, he or she becomes more vulnerable and is more likely to be victimised or turn to risky behaviour, such as prostitution, bullying, stealing or being disruptive. However, even children with good coping skills and resilience may still be harmed, abused or exploited<sup>19</sup>.

#### 4 | THE SOCIAL DEVELOPMENT APPROACH

The social development approach recognizes that the family is the basic unit of society, and plays a key role in the survival, protection and development of children. Its rationale is that families should be supported and their capabilities have to be strengthened for the purpose of meeting the needs of members. Theories encompassed in this approach recognize that families require a range of supportive services in order to promote family life and development. Over and above the foregoing, certain families may require additional supportive services so that they can solve problems in human relations, such as conflict, communication, parenting, substance abuse and family violence, as well as addressing problems that arise from life changes and events<sup>20</sup>.

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<sup>19</sup> Ibid.

<sup>20</sup> Midgley, James (1995). *Social Development – The Developmental Perspective in Social Welfare*. Sage Publications.

## Job Aid 4 | Strengths-based and resilience-based approaches

**Resilience** is the ability to recover from stresses and shocks and to stay as strong, or become stronger, than before. Resilience focuses on the positive aspects that help children cope and develop normally, or sometimes even do better, while living in difficult circumstances. Understanding the positive elements can help to identify the positive results.

A number of internal and external factors can contribute to increased resilience, including:<sup>21</sup>

- a good relationship with a least one caregiver;
- positive parenting – this means having a strong and open relationship with the child, doing everything possible to facilitate the child’s full development potential, and dealing with differences in non-violent and constructive ways, such as praising good behaviour, setting clear rules, taking time to listen, working as a team, and avoiding physical punishment;
- good educational opportunities;
- social relationships.

Research shows that children who are more resilient tend to have higher self-esteem and greater belief in themselves, along with a sense of having some control over their lives and the ability to make a difference for themselves and others. Being resilient does not mean that a person does not experience difficulty or distress. Emotional pain and sadness are common after suffering major painful experiences. The road to resilience often involves considerable emotional distress. The factor that is most important for a child is to have the support of caregivers:

*‘Children are able to be resilient, that is, to bear and recover from significant suffering, when they are surrounded by people who love and care for them. The sense of belonging and hope that is nurtured in these relationships enables children to cope with hardship, including hunger, illness, discomfort, and other deprivations of poverty and loss.’<sup>22</sup>*

### RESILIENCE AND STRENGTHS-BASED APPROACHES IN CASE MANAGEMENT

People involved in case management can do a lot to build up the resilience of children and their family members by:

- facilitating the participation of children and vulnerable families in the case management process – having a say can in itself provide strength;
- focusing on children’s and family’s strengths and resources so that the actions and possible solutions enhance these strengths;
- acting with respect, care and empathy, which is likely to bolster self-respect and self-belief in children and families.

A resilience- and strengths-based approach looks at the child’s whole world, and considers all the positive aspects of that world. On the following page is a triangle that highlights the different aspects of a child’s life:<sup>23</sup>

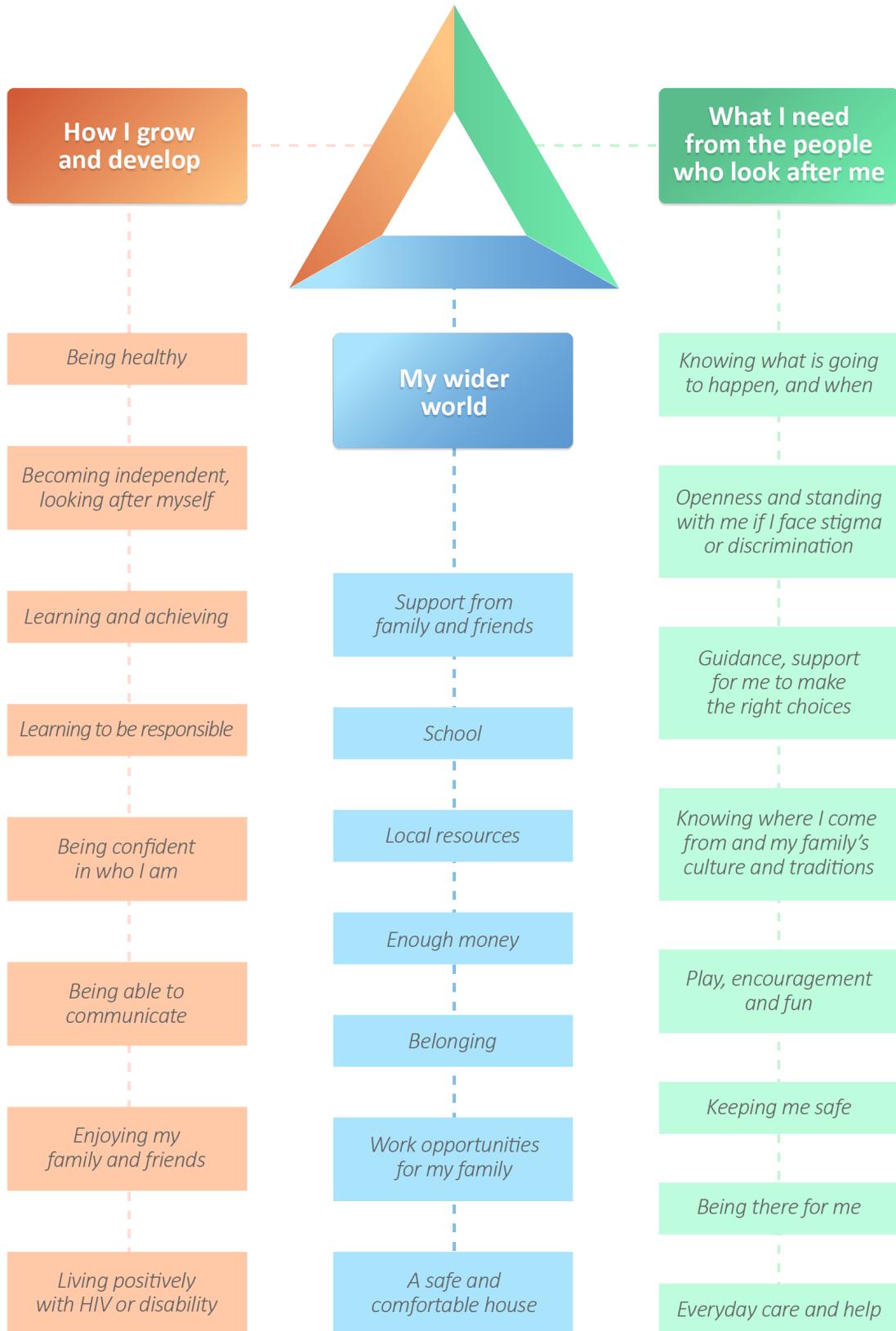
- what the child needs at an individual level;
- what the child needs from the people who look after him or her;
- how the wider world affects the child.

<sup>21</sup> Child Protection Working Group (2014). Inter-Agency Guidelines for Case Management and Child Protection.

<sup>22</sup> Richter, L.; Foster, G. and Sherr, L. (2006). Where the heart is: Meeting the psychosocial needs of young children in the context of HIV/AIDS. The Hague, The Netherlands: Bernard van Leer Foundation.

<sup>23</sup> Scottish Government. Getting It Right for Every Child National Practice Model: <http://www.gov.scot/Topics/People/Young-People/gettingitright/national-practice-model/my-world-triangle>

**My world triangle of strengths and resilience**



### CHECKLIST FOR ASSESSING RESILIENCE AND STRENGTHS

The most important part of case management is helping a child and family move from being highly vulnerable and unprotected to highly resilient and living in a protective environment. As part of the assessment, consider the following matrix:



A resilience-based approach means considering what the main challenges are that need to be addressed, and identifying ways to move the child into the top right-hand corner above.

Look at the categories in the ‘My World Triangle of Strengths and Resilience’, and identify where there are gaps that make the child less resilient. In all assessments, first list the potential strengths, and then identify with child and caregiver or family what might be needed. A case conference might be a way to bring in expertise from others in the community to suggest possible solutions.

On the following page, a strengths-finder tool asks some of the main questions. The child and family/caregiver may already have good ideas about what is working and not working. It is also useful for a social worker to start the discussion by focusing on the positive – talk to the child and family/caregiver about things that are really working well. Ask them if that always happens, and only then focus on why the good things do not always go well.

Once the challenges have been identified, look at what might already be addressed by doing things differently – what would make it possible for the child or adult to make a change that is concrete and achievable?

STRENGTHS-FINDER TOOL			
What makes me feel safe and secure	Where am I already strong?	What makes it hard to be strong?	What would help in making things better? Where can I get support?
<p><b>How I grow and develop</b></p> <p><i>Health</i></p> <p><i>Education</i></p> <p><i>Communication with important people</i></p> <p><i>Learning how to look after myself</i></p> <p><i>Being confident and being believed</i></p>			
<p><b>What I need from the people around me</b></p> <p><i>Providing guidance</i></p> <p><i>Providing stability</i></p> <p><i>Providing space to play and have fun</i></p> <p><i>Spending time with family and friends</i></p> <p><i>Being kept safe</i></p> <p><i>Providing everyday care and help</i></p>			
<p><b>What I need from the outer world</b></p> <p><i>Being able to go to school or training</i></p> <p><i>Having access to health care</i></p> <p><i>To feel safe in the community</i></p> <p><i>Knowing where to go when things are not safe</i></p> <p><i>Having a safe place to live</i></p> <p><i>Having enough money in the home</i></p>			

## Job Aid 5 | Promoting child and family participation in case management processes

### PRINCIPLES OF PARTICIPATION IN CASE MANAGEMENT

According to the CCPA, children have a right to express opinions about their experiences, and to participate in decisions that affect their protection and care. Giving a child and family the space to speak out and make decisions promotes resilience.

Children must be told that they have the right to express a view, and that if they do not want to share their view, that is all right, too. A child can explain why she or he chooses not to share their viewpoint if they desire – for example, a child may reveal that answering a particular question makes him/her feel uncomfortable.

Families also have a right to participate and to express their wishes for the child, and discuss what support, if any, they feel that they have. It may sometimes be useful or necessary to provide a safe space for a child or family member to speak confidentially. Ensuring safety and guaranteeing confidentiality are essential for participation. Children and families have the right to receive information in an appropriate format so that the child understands what is happening throughout the case management process.

Case conferencing is an important opportunity for a child and family/caregiver to voice their views. A social worker, or someone else who is trusted by the child, would ideally support the child and family before a case conference by reviewing with them what will happen and helping them prepare to express their wishes.

Children of different ages, maturity and capacity can make decisions in different ways. Even very young children are able to participate in decision making, although this may take time and the social worker will need to communicate with the child in an age-appropriate way to support the child in voicing her/his views.

Make sure that children know what is about to happen, who is responsible for making it happen, and how long it should take. Children should always know who they can contact and how they can do this, including in situations where children do not have access to phones. A social worker may need to identify and work with a trusted adult with whom the child is comfortable.

### SKILLS AND TECHNIQUES FOR COMMUNICATING WITH CHILDREN<sup>24</sup>

- Pay attention to what the child is saying and doing, and do not do anything else at the same time.
- Use simple language: think about the words you use. Long sentences will confuse children.
- Use a child's experience to explain things.
- Be friendly and approachable. Do not look bored, angry or worried while a child is talking, because this will stop him/her from talking. Maintain eye contact.
- Actively listen and respond to the child. Try to answer his/her questions as honestly as possible.
- Sit at the same level as the child.
- Provide adequate time and space and talk to the child in an appropriate and conducive environment.
- Make sure that the child knows you will observe confidentiality.

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<sup>24</sup> Adapted from A Holistic Approach to Psychosocial Support: A national training manual for caregivers of orphans and other vulnerable children in Uganda (Ministry of Gender, Labor and Social Development, Uganda; 2015).

- Be empathetic – show that you can understand what the child has been feeling (without saying that you are feeling it yourself).
- Do not be afraid of silence when the child needs time and space to gather thoughts.
- Encourage the child by nodding or smiling, but not too often to avoid distracting the child.
- Ask open-ended questions.
- Summarise and clarify regularly so that you are sure about what the child has said: make sure that you understand what the child is trying to say and clarify what the child knows about the situation.
- Do not rush children: be patient, go at their pace, and allow them to express their emotions.

Young children may find it easier to talk when discussion is facilitated by playing games, such as making sad or happy faces, or through pointing at happy or sad pictures. Facilitation may also help when communicating with a child who has a learning or speech impairment; in such cases, a social worker may want to get assistance from someone with ECD expertise or from a child's disability support worker. This must be done without breaching confidentiality.

At times, older children may not wish to share thoughts or feelings, or even share what happened due to fear of negative consequences for themselves or others. A child may feel that she/he was responsible, for example, if sexual abuse occurred when the child was out socialising. In such cases, it is important to make it clear that you are not being judgemental, and that it is normal and okay for teenagers to socialise. They may also be conscious of the consequences of 'getting other people into trouble'. The principle of confidentiality is important here. Some teenagers find it easier to communicate while they are walking or when they are in a vehicle, as long as others aren't around.

## Job Aid 6 | Basics of integrated case management<sup>25</sup>

A 'case management system' is the set of coordinated components that connect to each other and that are all necessary for individual children vulnerable to risk to benefit from targeted care. Case management has been used widely in HIV, health and child protection sectors, but it has always been hard to move beyond a single technical sector to having a system that works across different sectors and at different levels, to holistically address the individual child's risk to vulnerability.

An 'integrated case management system' is a case management system that is coordinated across different technical sectors that deliver direct services. The integration is framed by 'ground rules' across sectors that enable each person who supports vulnerable children to learn how they can work together in a harmonised and holistic way, and to be held accountable to the child and to the functioning of the overall system. There must be integration across relevant sectors, and from top to bottom of each sector (from the ministries at central government level to those who work in the community with the children and families).

A case management system that is truly integrated, at all levels, is likely to be:

- Less intrusive – for example, a child's right to privacy will be upheld more effectively when he/she does not have to repeat his/her experience of being sexually assaulted to a police officer, a social worker, a court probation officer, a psychosocial support volunteer and/or a health worker, because the initial account can be shared confidentially across sector with all people who have a need to know;
- More comprehensive – with all actors following the same processes, it is easier for a case manager (the person who is overall responsible for making sure that the child receives support) to ensure that all the correct steps have been fulfilled;
- Time and cost-efficient – working together can reduce the time and cost of gathering information if people work together, share information, and divide tasks (minimizing duplication while maximizing resources); processes are completed on time, and resources are not wasted by, for example, a delayed legal process;
- Inclusive of community-led and community-driven initiatives for vulnerable children – by ensuring linkages between all actors and focusing on accountable mechanisms for working together;
- User-friendly – if people work together in a more efficient way, the child and family members/caregivers should find it easier to know what is going on, and communication should be easier, thus supporting their right to informed participation.
- More effective – collaboration promotes communication and coordination through case sharing. Having perspectives from different stakeholders enhances learning and improves problem-solving. Integrated case management comprises more than just referrals. Case management involves supportive referrals and longer term case sharing, as needed. This can be accomplished through:
  - A. Direct relationship/communication between stakeholders;
  - B. Case conferencing amongst stakeholders involved in the case at any point during which it will be useful;
  - C. Through Child Care and Protection Forums in which issues can be discussed and problems addressed collectively.
  - D. While there can be numerous benefits resulting from integrated case management, it should be noted that some challenges may be encountered, so efforts should be made to minimize them:
  - E. The management of coordination requires time, energy and organization;
  - F. There can be a dependency on others' priorities and assigned tasks may not be performed as hoped/expected.

<sup>25</sup> Summarised from Integrating Case Management for Vulnerable Children: A process guide for assessing and developing an integrated case management system in Eastern and Southern Africa. (Maestral and UNICEF; 2017).

## Job Aid 7 | Case management for children affected by HIV

Case management is essential in HIV-prevention services and to support children and families living with and affected by HIV. HIV-sensitive case management can:

- Ensure that children who are in need of protective services are rapidly referred to HIV prevention and support services and that their HIV needs are followed up;
- Improve the chances for children and parents/guardians/caregivers/families who are isolated from health services to access HIV counselling, testing and treatment and support services;
- Increase and improve linkages between HIV prevention, care and support services and other family-strengthening services.

An HIV-sensitive case management system is a way to enhance HIV-affected children's and families' resilience, and it is highly recommended that any child living with HIV receives a level of case management.

Living with or being affected by HIV is a common factor in vulnerability and risk for children and their families in Namibia. The needs of children and adolescents living with HIV (LHIV) are often complex and changeable. Situations that are stable today can quickly become unstable, impacting adherence and emotional health.

For example, a medicine bottle falling out of a schoolbag and being seen by other children could traumatise the child and have an impact on adherence and well-being. Caregivers also have a lot of fears about the disclosure of status to their children. The better planned and supported this process is, the better the outcomes are likely to be for the child and the family.

Furthermore, there is conclusive evidence of the following:

- Children affected by HIV face increased exposure to abuse and violence or neglect, either within the household or in the community<sup>26</sup>;
- Children who are orphaned due to AIDS, or who live with an HIV-positive sick caregiver, are more likely to face physical and emotional abuse, even compared to other orphans. This may be because of the increased economic and stigma-related pressures that the child and family face, because the child is living with extended family members who are discriminating, or because of the impact of grief and trauma faced by the child;
- Children who have been affected by sexual abuse are at higher risk of sexual exploitation and other HIV risks according to global data. It is very important that clinic and community support for sexual abuse links to psychosocial support and HIV prevention;
- Children living with HIV have improved treatment outcomes when their psychosocial needs are met: much of the psychosocial impact relates to HIV stigma and results in neglect or abuse.

HIV-sensitive case management should include the following:

- Social workers trained in basic HIV prevention and treatment support skills, including knowledge about supporting HIV disclosure and promoting resilience in the face of HIV-related stigma and discrimination;

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<sup>26</sup> For more information, see Protection and resilience: A simple checklist for why, where and how, to coordinate HIV and child protection policy and programming (World Vision and UNICEF; 2016): <http://ovcsupport.org/resource/protection-and-resilience-a-simple-checklist-for-why-where-and-how-to-coordinate-hiv-and-child-protection-policy-and-programming/>

- Social workers aware of the barriers to accessing treatment and care for children and sufficiently knowledgeable about MoHSS referral procedures to be able to offer assisted referral into/back into care and support services.
- Active coordination between social workers supporting children in need of protective care and services that provide HIV testing and counselling, support for disclosure, and ongoing HIV treatment adherence;
- Active coordination between social workers, community health workers and community-based groups providing psychosocial support;
- Age-appropriate services that are sensitive to the needs of children living with HIV as they transition to adolescence and adulthood. Case management can enable adolescent boys and girls living with HIV the chance to access life skills, positive prevention and sexual and reproductive health services;
- Linkages between social workers and economic support, including pensions, education support and family strengthening. The biggest impact on reducing risky sexual practices amongst adolescent girls in heavily HIV-impacted countries is a combination of economic support and social welfare support. Case management services should link HIV-affected children and families with social protection services and social welfare support, such as parenting support, access to health care, etc.

Some potential roles of MoHSS and MGECW social workers to support children and adolescents living with HIV through case management include:

1. Early identification of HIV-affected and HIV-infected children through social investigation during case work;
2. Through appropriate questions, identify children and adolescents LHIV who are not yet in care or have dropped out of care, along with the reasons;
3. Offer counselling, information and assisted referral into/back into care and support;
4. Using knowledge of the disclosure process to identify children and adolescents LHIV who have not been disclosed to (according to age appropriate levels defined by MoHSS) or who are struggling post-disclosure, along with reasons why;
5. Offer counselling, information and support, paving the way for referral for disclosure by a health professional;
6. Identify mothers/caregivers LHIV who feel unable to disclose their own status to their children, along with the reasons and/or mothers/caregivers who are struggling with feelings associated with such disclosure. Offer counselling, support and appropriate referral;
7. Support children and adolescents LHIV and caregivers referred to them by MoHSS for more specialized, longer term counselling related to LHIV and disclosure and in complex cases where other issues are detected by health care professionals;
8. Assist with post-disclosure support to promote healthy reflection, relationships and support.

When a social worker identifies a child/family affected by HIV, the questions below may be used, as appropriate, to build a picture of the challenges faced, as well as the resilience to overcome them, with a view to supporting appropriate referral to HIV services.

<p>Are you or any of your family members in need of information about HIV and available HIV services?</p>	
<p>Are you or any of your family members in need of testing or re-testing for HIV?</p>	
<p>Are you or any of your family members in need of support with disclosing HIV status?</p>	
<p>Are you or any of your family members in need of ARV adherence counselling? If yes, what are the challenges with taking ARVs?</p>	
<p>Are you or any of your family members living with HIV going to the clinic regularly for HIV follow-up (<i>at least twice per year</i>)? If not, what are the challenges?</p>	
<p>Do you or your family receive any other HIV support or services? <i>If yes, provide name, agency.</i></p>	

## Job Aid 8 | Gaining informed consent and informed assent

### AGE OF CONSENT FOR CHILDREN IN NAMIBIAN LAW AND POLICY

In Namibia, children reach the ‘age of majority’ and are seen as adults with full legal capacity at 18 years (CCPA, Article 10). This means that most decisions made by children under the age of 18 (‘minors’) need to be done with the consent of one or both parents or a guardian.

The Child Care and Protection Act clearly states that children’s best interests are paramount. This means that the child’s safety and protection come first – if a parent or guardian refuses consent, but a social worker or children’s commissioner decides that it is in the child’s best interest for an action to be taken or a decision made, then consent is not required.

AGE AT WHICH CHILDREN IN NAMIBIA DO NOT REQUIRE PARENTAL CONSENT	
Consent to HIV testing	14
Consensual sex with someone also of an age to legally consent to sex	16
Driving	17 for learners; 18 for drivers
Drinking alcohol	18
Age of criminal responsibility	7
Access to sexual and reproductive health care, including contraception	14
Age of informed consent	10

### CONSENT IN RELATION TO CHILDREN WHO MAY BE IN NEED OF PROTECTIVE SERVICES

Consent should be sought from children and from parents or guardians at all stages of the case management process. Consent means giving permission to a social worker, or other person offering services or support, to:

- Ask questions of children or other family members, and record the answers;
- Pass on essential information to others who have a role in providing services or support. This must be confidential and only such information as the other person needs to know in order to be able to provide the support;
- Make recommendations to the court, where needed. A child or adult does not have to agree to what the recommendation is because these must be in the best interests of the child, but it is good practice to ensure that the child and adults in the case know what is being recommended.

**Informed consent** is the voluntary agreement of an individual who has the capacity to give consent, and who exercises free and informed choice. This means:

- Explaining why you are asking the child or others questions and in whose interests;
- Explaining what you will do with the information;
- Ensuring that the child or adult understands the process, and has a chance to ask questions;
- Ensuring that the child or adult knows what may happen next;
- Ensuring that the child or adult knows they can ask for clarification and support at any time.

**Informed assent** is used when a child is too young to give informed consent, but is old enough to understand and agree to participate in services. Assent in this case may be verbal. In such cases, the social worker should clearly record the verbal assent provided, stating how this was provided, in process notes.

## WHEN CONSENT IS AND IS NOT REQUIRED BY THE CCPA FOR CHILDREN IN NEED OF PROTECTIVE SERVICES

Consent is required from the child or children when:

- A social worker wishes to enter a residence to get information in relation to the safety of a child who may be in need of protection services, unless the social worker is accompanied by the police and either has a warrant or is confident that a warrant will be issued;
- The child is to be adopted, if the child is over the age of 10 years or if the child is under the age of 10 years, but of sufficient maturity and stage of development to understand the effect of giving consent.

Consent is not required from the child's parent or guardian when:

- The child is offered or requests legal representation or assistance for any proceedings at a children's court (Article 58:7).

In relation to guardianship and therefore consent, if a child has parents who are themselves under the age of 18 years and are not married, then guardianship of both parent and child is held by the parents' own guardian[s], unless a court has directed otherwise.

## KEY STEPS IN SEEKING INFORMED CONSENT OR INFORMED ASSENT

At all stages, case workers should explain why they are talking to the child or adult, for example, explaining that someone has expressed concern and why. It is important to give this information in a non-judgemental way, making it clear that the social worker is looking for facts, and not automatically believing allegations. Make sure that all relevant people have a chance to talk about the situation and express their views and opinions. It is good practice to encourage children who are old enough to make a decision on their own to still involve their families in decision-making, and vice versa.

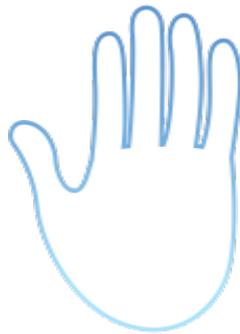
Document any information relevant to the consent. If a child or adult should give informed consent but is not able to because, for example, she/he may be unconscious or unable to make a decision due to pain or the effects of alcohol, then this should be recorded and consent sought when the adult or child is able to at a later time.

It is important not to automatically assume that a child or adult with intellectual impairments or any other disability is not competent to make his or her own decisions. If a social worker is undecided, she/he should seek the advice and support of the child's or adult's health worker or discuss the situation with someone with disability expertise.

For a child or adult to be able to give consent, she/he must be able to:

- Show that she/he understands and can remember key information relevant to the decision or action that requires consent, including the key potential negative and positive consequences of the action;
- Show that he/she has used this information to give consent, for example, by explaining why consent is being given in his/her own words;
- Give the consent voluntarily. This means knowing that she/he can also say 'no' without suffering consequences. In cases where a decision or action is against the wishes of the child or adult, the social worker must state that consent was not provided, but the action taken in the best interests of the child, and must also be able to explain why.

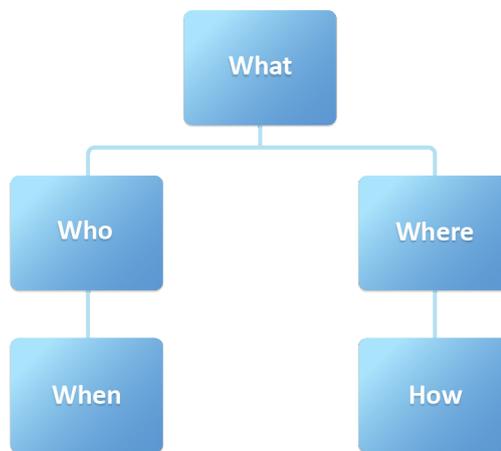
## Job Aid 9 | Interviewing hand model



The hand model is a tool which can be used to elicit information from a child or adult during an interview or therapeutic session. Use the hand to keep focus and to guide the session. Use the hand of the client, so they feel a sense of ownership. The model can help with many aspects of case management, including making decisions about case conferencing, addressing pre- or post-HIV disclosure issues, and discussing strengths and resilience.

**EXAMPLE:** In the **palm** of the **hand**, write the **main problem** as formulated and experienced by the client. Use a **finger** to **identify possible solutions or interventions for the problem**. By using their own hands, clients will remember decisions taken, and this will help them in working towards achieving the therapy goals.

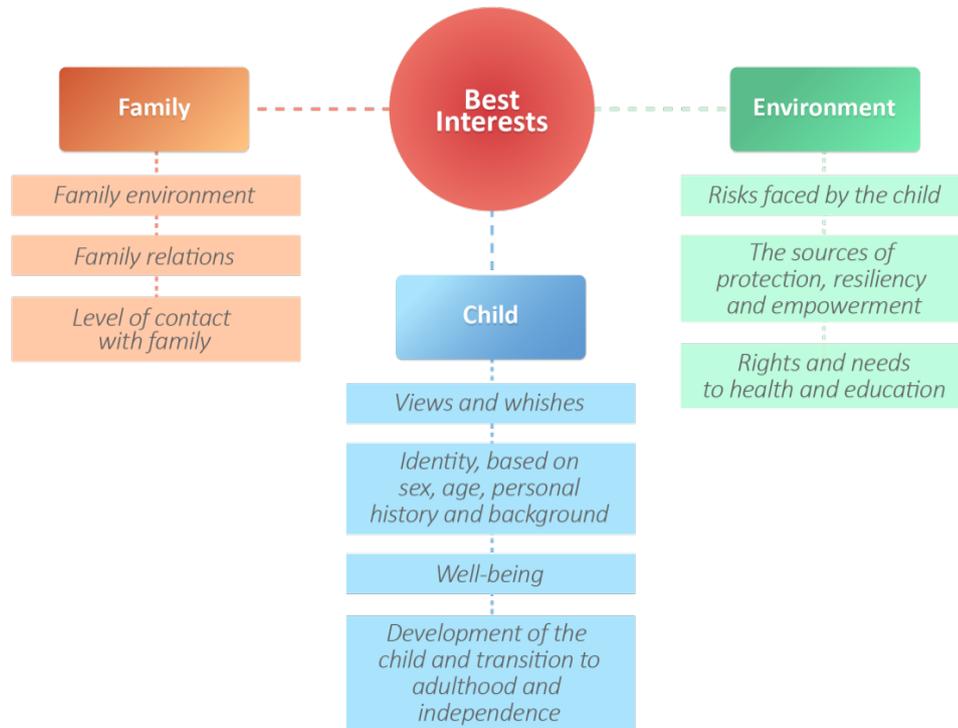
The fingers can be used to answer the following questions:



Getting to know the client and building trust <i>(children living and working on the street)</i>	Stakeholder Matrix
<input type="checkbox"/> Get to know your client by asking them to tell you five things they do during the day	<input type="checkbox"/> Identify activity in the palm of the hand
<input type="checkbox"/> The child can list five ways how he/she survives on the street	<input type="checkbox"/> Start listing the primary stakeholders and roles
<input type="checkbox"/> The child can list the support system (persons) he has on the street and at home	<input type="checkbox"/> List the secondary stakeholders and roles

## Job Aid 10 | The best interests of the child<sup>27</sup>

The principle of ‘best interests of the child’ was set out in the UN Convention on the Rights of the Child. It means balancing all the different elements that inform a child’s well-being and enable the child to fulfil his or her rights.



### WHO NEEDS TO TAKE BEST INTERESTS OF THE CHILD INTO ACCOUNT

Every adult should always think about what is best for a child in both the short and long terms. However, it is the social worker who must apply the ‘best interests’ principle when making assessments.

### WHEN TO TAKE BEST INTERESTS INTO ACCOUNT

The Child Care and Protection Act of 2015 (Article 3) states that in all matters affecting a child or children in general, **the best interests of the child concerned are the paramount consideration**. The following two steps in case management explicitly require a documented ‘best interests’ decision:

1. A decision about whether a **child should be removed from his or her home** or whether an alleged offender should be removed from the home following a report from a member of the public or a professional that a child may be in need of protective services (to be noted on Form CM2: Intake and Rapid Risk Assessment, and if required, on CM3: Social Investigation) or updated action based on Form CM 6: Case Conference Record;
2. Decisions related to the type of ongoing case management support provided and overseen by the court, in cases where a child is in need of protective services (Form CM4 Court Report) and other specialized forms related to alternative care).

<sup>27</sup> Cantwell, N.; Davidson, J.; Elsley, S.; Milligan, I.; Quinn, N. (2012). Moving Forward: Implementing the ‘Guidelines for the Alternative Care of Children’: <https://www.celcis.org/files/4514/5450/2144/Moving-Forward-implementing-the-guidelines-for-alternative-care-for-children.pdf>

## KEY AREAS WHEN CONSIDERING A CHILD'S BEST INTERESTS<sup>28</sup>

- The child's **own freely expressed opinions and wishes** (based on the fullest possible information), taking into account the child's maturity and ability to evaluate the possible consequences of each option.
- The **situation, attitudes, capacities, opinions and wishes of the child's family members** (parents, siblings, adult relatives, close 'others'), and the nature of their emotional relationships with the child.
- The **level of stability and security** provided by the child's day-to-day living environment (whether with parents, in kinship or other informal care, or in a formal care setting):
  - A. Whether the child is facing immediate risk
  - B. The level of stability and security that the child has received over time (Form CM3: Social Investigation);
  - C. The potential level of stability and security if the child remains in the same environment (e.g., with any necessary support and/or supervision);
  - D. The potential level of stability and security in any of the other care settings that could be considered.
- Where relevant, the **likely effects of separation** and the potential for family reintegration.
- The child's **special developmental needs** related to a physical or mental disability, to HIV status and impact, or related to other specific characteristics or circumstances.
- Other issues related to a child's individual or social well-being, for example, the child's **ethnic, religious, cultural and/or linguistic background**, so that efforts can be made, as much as possible, to ensure continuity in upbringing and maintenance of links with the child's community, and preparation for **transition to independent living**.
- A **review of the suitability of each possible care option** for meeting the child's needs, in light of all the above considerations.

The Child Care and Protection Act states that a child's best interests must be paramount. This means that each time a decision is to be taken in relation to a child's rights (for example about the child's health, access to school, with whom the child lives, a legal decision, etc.), the person or people who are responsible for making the final decision **must have access to all the available and necessary information** using the above elements. They must then apply that information to the decision.

Often different adults have differing opinions about what is best for the child, and these must all be considered and explored.

It is also important to take into account the rights and legitimate interests of others when considering a child's best interests. This may include both parents/caregivers (who may have different views), other siblings and family members or other people in the community.

Considering the child's best interests may mean making one choice amongst a number of different options that are all possible and appropriate.

Making a decision in the best interests of a child means identifying the **best** decision among several options, in both the short and long terms, and considering both short- and long-term benefits across all aspects of a child's life.

<sup>28</sup> Adapted from Moving Forward: Implementing the 'Guidelines for the Alternative Care of Children' (Cantwell, N., Davidson, J., Elsley, S., Milligan, I., Quinn, N.; 2012): <https://www.celcis.org/files/4514/5450/2144/Moving-Forward-implementing-the-guidelines-for-alternative-care-for-children.pdf>

## CHECKLIST<sup>29</sup>

Social workers may find this checklist useful before making a final decision in a child's best interests.

### VIEWS OF THE CHILD

- Have you explored the child's wishes and feelings? Did the child share these views directly?
- Have you made a decision about the weight to be given to the child's views, in light of the child's age and maturity?
- Have you taken into account the child's ability to comprehend and assess the implications of the various options? Have you provided information in a way that is appropriate for the child's age and maturity?

### SAFE ENVIRONMENT

- How safe is the household overall (in relation to exposure to danger from alleged perpetrators, from the community or from other environmental factors)?
- Is the child, or the child's parent or guardian, able to access life-saving health care, or contact a social worker or police, if this is a consideration in the case?

### FAMILY AND CLOSE FAMILY AND COMMUNITY RELATIONSHIPS

- What is the capacity of parents/caregivers/ guardians to care for the child?
- What support do the parents/caregivers/ guardians receive from community members or institutions?
- What is the potential effect of separation from family or change in care-givers on the child? If temporary placement needs to be considered:
  - A. What are the prospects for care in a family setting, such as kinship or foster care?
  - B. What are the prospects of using community care systems (provided they are safe and effective), for example, providing ongoing support to a child- or youth-headed household?
  - C. What options are there for maintaining continuity of contact (e.g., under supervision) and ensuring separation for the shortest duration and early deadline for review?
- How best to ensure retention of family and sibling relationships?
- Have you considered the quality and duration of the relationships and the child's degree of attachment to siblings, other family members, other adults or children in the community who provide social or cultural support, or to a potential future caregiver (if the risk relates to parent or current guardian)?
- What is the capacity of current and potential future caregivers to care for the child?

### DEVELOPMENT AND IDENTITY NEEDS

- Do the care and support options provide continuity within the child's ethnic, religious, cultural and linguistic background?
- Do the options take into account specific considerations based on age, sex, ability and other characteristics of the child?

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<sup>29</sup> United Nations High Commission for Refugees (2008). UNHCR Guidelines on Determining the Best Interests of the Child: <http://www.unhcr.org/4566b16b2.pdf>

- Do the options take into account any disability-specific or HIV-specific considerations, such as access to health and social support, and support to combat stigma and discrimination?
- Have the child's physical, mental and emotional health considerations been taken into account?
- Have the child's current and future educational needs been considered?
- Have the child's prospects for successful transition to adulthood (employment, marriage, own family) been taken into account?

## Job Aid 11 | Registration and filing

Case management is only effective if it is complemented by a systematic approach to work. An effective case management system comprises:

- **Screening** that allows for good client service in a MGECW office, and also captures basic data on each person requiring assistance.
- **Registration** that allows for tracking of cases from identification to termination.
- **Filing** and repository of cases in a central place.
- **Documentation tools** that allow a social worker to record information gathered through the case management process.
- **Allocation** of cases to social workers in a manner that is equitable and fair.
- **Supportive supervision** to assist social workers with caseload management.

In this job aid, we focus *primarily* on the registration and filing elements of the system.

### SCREENING AND REGISTRATION

It is essential that all clients presenting to an office are recorded and counted through registration. This enables individuals and supervisors to accurately capture the traffic through their offices, the reasons for visits, the number of referrals made and the number of visits which resulted in a case being opened. This data is invaluable in building local, regional and national pictures of social work, and acts as supporting evidence for reporting. Registration is also critical to customer service, as clients' records can be effectively tracked for easy referencing and efficient follow-up.

The means of registration may vary from office to office, depending on particular circumstances, but whatever approach is adopted, the end result must be the same. The model below is seen as the ideal practice for achieving effective registration.

1. Administrative officers should screen any presenting client for services (beyond the grant) and capture basic information on the Administrative Officer Screening Form (AO1). **See step 2 on screening in the SOPs.** The forms are collected in a file, by month. As may choose to additionally keep registration books for their own tracking purposes. Data in these forms will provide information on the initial and primary reasons for visits to the office.
2. Referral-out forms (CM5) are kept to record referrals made and to whom clients are referred. For referrals to social workers, CM1, Part 1, should be completed.
3. At intake (**see Step 2 in SOPs**), social workers enter clients in a registration book to track all incoming social work cases (reports-in, referral calls and self-referrals), as outlined in detail below. It is ideal for one registration book to be used by all social workers in an office, wherever practical. Social workers may choose to keep their personal register for tracking their own cases in any way which suits them, and is approved by their supervisor.

For setting up the office registration book, the structure should be:

- **Page 1:** Copy of the risk assessment matrix for easy referencing.
- **Page 2:** Categories for referencing (using categories listed in the Ministry's filing system and a list of stakeholders).
- **Remaining pages from front**

Left side of registry book:

Date	Last, First Names	M / F	Date of Birth	Parent / Guardian	Contact Details	Referred by (Self/Other)
DD/MM/YYYY			DD/MM/YYYY			

Right side of registry book:

Constituency / SW	Case Type	Risk: low, medium, high	Due Dates	Referrals Out	Case Number	Remarks

The registers must be reviewed on a monthly basis at least, and more frequently if possible, by the appropriate supervisor.

## CASE CATEGORIZATION/CLASSIFICATION AND ASSIGNING OF FILE NUMBER

The allocation of file numbers in the Ministry of Gender Equality and Child Welfare is guided by the Filing System as approved by the National Archives in 2013 and rolled out to all the regions.

Individual case files are not entered in the Master Copy of the Filing System as kept by the Control Officer in the Ministry of Gender Equality and Child Welfare, but form part of the 'Register of Files Opened' – see paragraph 16 of the Filing System.

Case files form part of the numerical layout of the filing system, starting with the **case category**.

Each region is assigned a number. For example, Kavango East is Region 4 and Kavango West is Region 5. Similar to regions, each constituency is also given a number.

The process of assigning a file number adopts the following sequence: **Category – Region – Constituency – Month – Year – Sequential Number – Surname and 2 initials**. In cases in which there is more than one child, an alphabetical system will be used, starting at the beginning of the alphabet an 'a' denotes the child/client with the presenting problem, and other siblings are assigned the next letter in the alphabet.

An example to illustrate this practice is: Otto Ndumba Haingura presents for foster care in Mashare constituency in Kavango East in May of 2017; his file number would then be: 12/2/7-4-1/ 0517001 Haingura ON (a), made up of:

- **Category:** 12/2/7
- **Region:** 4
- **Constituency:** 1
- **Month:** 05; **Year:** 17; **Sequential Number:** 001
- **Surname AND TWO INITIALS:** Haingura ON (a), sibling 2 (b) sibling 3 (c)

The following table illustrates the writing of the file number on the case folder

Category			Region	Constituency	Month		Year		Sequential Number			Surname, Initial, Initial
12	2	7	4	1	0	5	1	7	0	0	1	Haingura ON a

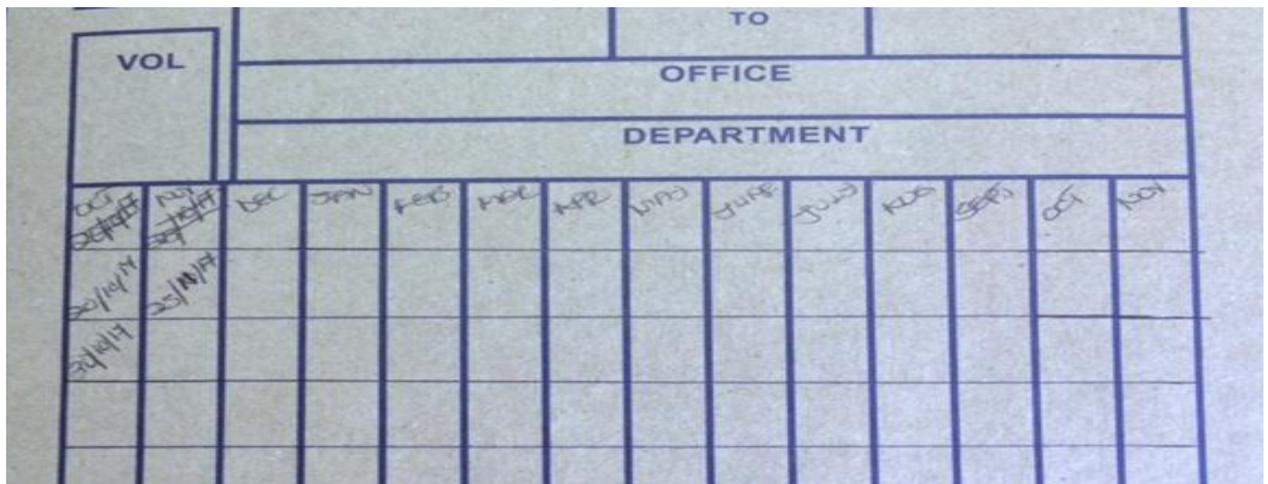
The sequential number will be allocated as clients are registered, irrespective of their presenting category.

### ALLOCATION OF CASES

Once the registration is done, and in offices where there is more than one social worker, cases are allocated by the supervisor. This enables the supervisor to manage caseloads between social workers and to better track progress.

### FILE MANAGEMENT

- All files opened at intake, once captured on a paper-based or electronic register, must be filed and stored in accordance with the agreed-upon filing plan, e.g., in cabinets or boxes placed on shelves, etc.
- Short-term/low-risk cases should be filed in the lever arch file. All medium- and high-risk case documents, including forms completed by the social worker, must be filed in a brown case folder. On the outside of the case file, one should draw grid lines and list the months of the year. With each action, the front is updated, as seen below:



- The table below demonstrates the layout of the inside of the case file:

LEFT INSIDE LEAF <i>(section forms inserted with case allocation for easy referencing)</i>	CENTRE INSIDE LEAF <i>(section forms/documents being added as the case develops)</i>	RIGHT INSIDE LEAF <i>(section forms inserted with case allocation)</i>
1   Reporting form ( <i>bottom</i> ) 2   Consent form 3   Demographic profile ( <i>top</i> )	1   Remaining intake ( <i>bottom</i> ) 2   Any client documents 3   Social investigation 4   Care plan/case conferencing 5   Follow-up/case reviews 6   Any other documentation received 7   Case closure ( <i>top</i> )	1   Supervision logs – 3 blank copies ( <i>bottom</i> ) 2   Case-tracking form

## FILE STORAGE

It is an acceptable practice for each social worker to store his/her files in the office to ensure confidentiality; however, of files must be organised according to a policy that outlines how files must be stored, indexed and categorized. In addition, the policy mandates that who can have access to social work files be clearly indicated. Files should be stored in file cabinets according to the main categorisation number, e.g. 12/2/7/ (7 denotes the categorisation of foster care), therefore all foster cases belong together, as do cases of child exploitation, gender gender-based violence, etc. Removing and returning of files

- The movement of files between social workers' filing cabinet and case managers must be controlled by means of a register. This is to ensure that clients' files can be tracked between social workers and supervisors.
- When a file is removed, it is common practice to place a holder to indicate that it has been removed. This can be an empty folder or a card with the name and number of the file that has been removed, as well as the name of the person who has removed it.
- This registration should be kept at the back side of the registration books. At times, a case may be borrowed for review (for example, when a client system is across two constituencies/regions), and the file will be returned upon completion of the review; however, if a child has moved and is then transferred to a different social worker and/or region, the file is not expected to return.
- When a file is removed, the social worker or supervisor removing the file must complete a removal register. Below is an example of such a register.

Client name	File reference number	Name of case worker requesting the file	Date of removal of the file	Date of return of the file

## Job Aid 12 | Child development as it relates to child protection<sup>30</sup>

It is important to have a basic knowledge of how a child develops, and how a child relates to her/his family and to the larger world for case management. This knowledge assists in assessing a child's strengths and resilience, as well as in assessing the various individual, family and social risks when deciding what is in the child's best interests.

### AGES AND STAGES OF DEVELOPMENT AND THE ENVIRONMENT

Child growth and development refers to the progression of life from birth to adulthood.

Each child is unique at birth. The differences among children affect how they develop. Development is influenced by:

- **Heredity:** physical and intellectual characteristics passed down from your family (DNA).
- **Environment:** the people, places and things that surround a person.

Development occurs in different areas:

- **Physical** – body, brain;
- **Cognitive or intellectual** – how the brain receives, interprets and sends messages;
- **Social** – interacting with other people;
- **Emotional** – understanding and expressing one's own emotions and having a sense of one's own unique identity;
- **Moral** – basing behaviour on personal beliefs about what is right or wrong.

There are many theories about how children develop, and many of these are based on research generated in the West; however, there are some common points of agreement across cultures and regions; these are reflected in the UN Convention on the Rights of the Child and the African Charter on the Rights and Welfare of Children and in Namibian law.

### KEY THEMES AT DIFFERENT STAGES OF CHILD DEVELOPMENT

PHASE	KEY CHARACTERISTICS	PRIORITIES FOR GOOD DEVELOPMENT
<b>Infants</b> (0-2 years)	<ul style="list-style-type: none"> <li>▪ <i>Rapid brain development</i></li> <li>▪ <i>Learn to move</i></li> <li>▪ <i>Form attachments and express basic needs</i></li> </ul>	<ul style="list-style-type: none"> <li>▪ <i>Safety and security and love</i></li> <li>▪ <i>Stimulation for brain development</i></li> <li>▪ <i>Nutrition for growth</i></li> </ul>
<b>Preschool childhood</b> (3-6 years)	<ul style="list-style-type: none"> <li>▪ <i>Curiosity</i></li> <li>▪ <i>Communication</i></li> <li>▪ <i>Imagination</i></li> </ul>	<ul style="list-style-type: none"> <li>▪ <i>Reassurance</i></li> <li>▪ <i>Stimulation through play</i></li> <li>▪ <i>Developing social skills</i></li> </ul>
<b>Primary school</b> (7-10/12 years)	<ul style="list-style-type: none"> <li>▪ <i>Friendships</i></li> <li>▪ <i>More mobility</i></li> <li>▪ <i>Beginning to challenge parents or caregivers</i></li> </ul>	<ul style="list-style-type: none"> <li>▪ <i>Starting to learn skills</i></li> <li>▪ <i>Learning right from wrong</i></li> <li>▪ <i>Space to develop friendships</i></li> </ul>
<b>Early adolescence</b> (10/12-14 years)	<ul style="list-style-type: none"> <li>▪ <i>Peer groups</i></li> <li>▪ <i>Beginning to challenge adult rules</i></li> <li>▪ <i>Insecurity and confusion</i></li> </ul>	<ul style="list-style-type: none"> <li>▪ <i>Learning</i></li> <li>▪ <i>Allowing some freedom, but maintaining consistency in rules</i></li> </ul>
<b>Later adolescence</b> (15-19 years)	<ul style="list-style-type: none"> <li>▪ <i>Risk-taking behaviours</i></li> <li>▪ <i>Starting to make decisions</i></li> <li>▪ <i>Growing sexuality</i></li> </ul>	<ul style="list-style-type: none"> <li>▪ <i>Helping adolescent to begin taking responsibility for the future</i></li> <li>▪ <i>Love, support and guidance</i></li> </ul>

<sup>30</sup> Job Aid 12 adapted from Child Protection Case Management Framework (Government of Malawi, Department of Social Welfare; 2015): [http://www.socialserviceworkforce.org/system/files/resource/files/Child%20Protection%20Case%20Management%20Framework%20Malawi\\_0.pdf](http://www.socialserviceworkforce.org/system/files/resource/files/Child%20Protection%20Case%20Management%20Framework%20Malawi_0.pdf)

## CHILD DEVELOPMENT AND CHILD PROTECTION<sup>31</sup>

Below are some indications that a child may be in need of protective care; however, it is always important to find out more about each child.

### ALL AGES

- Talks of being left home alone or with strangers or with people who do not feel safe
- Poor bond or relationship with parent/caregiver
- Acts out and/or excessive violence towards other children
- Lacks social skills and has few if any friends

### 0-2 YEARS

- Doesn't cry or respond to parent's presence or absence from an early age
- Reaches developmental milestones late, such as learning to speak, with no underlying medical reason
- Significantly underweight with no underlying medical reason, but eats well when given food

### 3-6 YEARS

- Doesn't cry or respond to parent's presence or absence from an early age
- Significantly underweight with no record of underlying health problems, but eats well when given food

### PRIMARY SCHOOL AGE

- Becomes secretive and reluctant to share information with teachers or other adults
- Reluctant to go home after school or reluctant for others to visit the home
- Poor school attendance that has become worse over time
- Parents show little interest in child's performance and behaviour at school
- Wets or soils the bed

### ADOLESCENCE

- Drinking alcohol regularly
- Is concerned for younger siblings without explaining why
- Is secretive and reluctant to share information
- Talks of running away or shows self-harming behaviours
- Shows challenging/disruptive behaviour at school.

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<sup>31</sup> Adapted from Signs and symptoms of child abuse and neglect (National Society for Prevention of Cruelty to Children [UK]): <https://www.nspcc.org.uk/preventing-abuse/signs-symptoms-effects/>  
Note that this is a UK-based organization, and Namibian social workers will need to consider any cultural differences.

## Job Aid 13 | Guide to case conferencing

### DEFINITION

A case conference is a **formal, planned and typically multidisciplinary meeting involving service providers from a variety of fields involved in the care of a vulnerable child and/or family**. The aim is to review service options across sectors and agencies, and **make formal decisions with the best interests of the child in mind**. A case conference can take place at any time during the case management process, but is considered a priority during the development of a care plan and planning of follow-up activities.

Case conferences are thus formal meetings in which a **number of service providers** who are supporting (currently or have the potential to support) the child and his/her family are formally invited to a **discussion with regard to concerns, bottlenecks or challenges regarding a child or children and the family**. It enables a collective review of the case, and minimizes the family searching for different services. Social workers should note that not all cases require a case conference. Case conferences are usually reserved for complex cases in which multiple challenges are observed, and therefore **need collaborative efforts from service providers for effective resolution**.

Within MGE CW social workers are the main drivers of case conferencing and, as such, should abide by the principles of case management which are informed by and reflect many of **the core values and principles of social work**<sup>32</sup>. In Namibia, this is upheld through the Code of Ethics and the CPPA as the statutory instruments that inform case management practice. In addition, the **case management guiding principles** (see page 16) must inform all decisions made about a case:

Case conferencing in Namibia will most probably take the form of a **multi-disciplinary team approach** whereby the social worker, on behalf of a client and his or her family, calls all the key actors from different Ministries or NGOs to meet and discuss the challenges faced by the client for action and planning purposes. **In most cases the family is not invited to a case conference, but can participate if it is well coordinated, planned and facilitated by the professional**. The onus rests on the social worker to adequately prepare the family to participate, and ensure that they are not exposed to further trauma.

**Case conferencing is not synonymous with family group conferencing**. A family group conference (FGC) is a restorative approach practiced in social work that builds on the strengths of the family to ensure protection and well-being of children. The key objective of FGC is to provide the family group (which includes nuclear and extended family, as well as friends) with a voice in the decision-making process to ensure the safety and well-being of children<sup>33</sup>.

Case conferencing can occur **internally to the Ministry, or externally**. **Internally** means that it can occur amongst social workers and other actors working in the MGE CW; for example, between a GBV unit social worker and a regional- or constituency-level social worker. This may happen at the national, regional or constituency level, or between levels, especially when policy issues are creating the bottlenecks. **Externally** denotes service providers that are outside the Ministry. A case conference at this level is a multidisciplinary approach in which various actors involved in the case of the child and family come together to explore multisector service options that are available and could support the case, facilitate cross-sectoral referrals, and make formal decisions in the best interests of the child<sup>34</sup>. These actors could be either governmental or non-governmental. The participants involved in such a case

<sup>32</sup> National Association of Social Workers (2008). Code of Ethics: <https://www.socialworkers.org/About/Ethics/Code-of-Ethics/Code-of-Ethics>.

<sup>33</sup> Adapted from Family Group Conferencing as a culturally adaptable intervention: Reforming inter-country Adoption in Guatemala: Rotabi Smith, Karen; Pennell, Joan; L. Roby, Jini L.; McCreery Bunkers, Kelly; 2012).

<sup>34</sup> Adapted from Standard Operating Procedures for Case Conferencing within Orphan and Vulnerable Child Programming: South Sudan (4 Children; May 2017).

conference will depend upon the nature of the case. At a local level, the CCPF has been identified as the platform in which case conferencing can be utilised as a tool to ensure children remain out of the statutory system and receive more supportive community-based services.

Case conferencing does not always deal with a 'case', but can also be utilised to discuss trends or patterns that social workers observe when conducting caseload analysis. Case conferencing can occur internally and escalate to the regional or national level in order to inform a policy or legislative change. In addition, at a national level, the MGECW and MoHSS can use case conferencing as a tool in order to obtain greater clarity and streamline their responsibilities between adults and children in cases that fall between Ministry mandates.

## A. PROCESS OF CASE CONFERENCING

The planning for a case conference is essential, as it is a formal meeting; therefore, the social worker should prepare for the case conference which includes the following:

### PREPARATION

- Create a report that contains all case information to be addressed.
- Develop an agenda to give structure to the case conference, include the objectives and purpose of the case conference. This is to differentiate whether this case conference is addressing a specific issue with which the family is dealing and for which they need the support of other service providers; advocating to obtain support services for the family; or developing a care plan for the family.
- Obtain input of a supervisor to ensure that the case conference agenda will lead deliberations towards the desired outcomes.
- Determine who needs to attend the case conference: the nature of the case will assist the social worker in determining who should attend. Case conferencing is linked to the care plan.
- Send meeting invites to all individuals expected to attend the case conference 14 days before the meeting date. This invitation should be accompanied by any information that will allow the participants to familiarise themselves with the case.

## B. HOLDING THE CASE CONFERENCE

- This is a formal meeting for which all involved should give consent, and sign a confidentiality form if necessary.
- Assign one person to take minutes to document the discussions and decisions made during the case conference. A case conference record form (CM6) must be used to document the proceedings.
- Once the case is presented, the objectives of the case conference should lead discussions. Input should be sought from other providers regarding how to address issues that are identified as concerns, challenges and bottlenecks that are keeping the child or family from making progress. All types of necessary support should be discussed, as well as any decisions regarding the most appropriate interventions in the best interests of the child.
- Any type of case conference is intended to help to clarify the child's and family's situation and behaviours, gain agreement regarding the best way to proceed, and make needed adjustments to the care plan.
- Meeting etiquette should be followed throughout the case conference, and the meeting should end by outlining the way forward and informing participants of any expectations and other issues that were discussed.

### C. FOLLOW-UP FROM THE CASE CONFERENCE

- The social worker has the responsibility to ensure minutes are recorded and shared with all participants within a reasonable time period.
- The social worker should provide feedback and seek guidance from her/his supervisor regarding decisions made during the meeting.
- If the nature of the meeting was to develop or review a care plan, the social worker must review the care plan to ensure that all decisions and actions resulting from the case conference are included in the care plan.

### D. THE OUTCOMES OF THE CASE CONFERENCE

- Determine what is in the best interests of the child, and decide on the appropriate interventions that will achieve this principle.
- Develop, review or improve the care plan.
- Apply mediation approaches with the family to support the child.
- Help the family (and stakeholders) prioritize issues as short-term, medium-term and long-term goals.
- Identify bottlenecks.
- Settle disputes.

A social worker should be aware that case conferencing does not substitute for case follow-up, which allows one-on-one contact with the child and family/caregiver.

## Job Aid 14 | Guide to setting up a case management system in your region

Case management demands that there be an enabling environment that supports the practice of case management to:

- strengthen the capacity of the social workers to perform their functions to the best of their abilities;
- ensure that supporting processes are undertaken in a systematic manner;
- provide a structural arrangement that enables the performance of functions;
- improve the use of data collection tools for documenting case management processes.

### MGECW STRUCTURE FOR CASE MANAGEMENT

A national office typically delivers services to the internal staff and serves as an oversight body for all regional and constituency offices. A regional office typically delivers services according to a two-pronged approach, namely centralised (regional office having supervisors and operational staff) and decentralised (constituency level having only operational staff) service delivery systems. Notwithstanding the type of delivery system, the functions performed from a central or decentralised point are the same. The difference is, within a centralised delivery system, more human resources, such as social workers and administrative officers are available, and some functions can be shared on a rotation basis; whereas in a decentralised system, there are fewer human resources, i.e., one social worker and one AO perform all functions.

The functions performed by social workers can normally be divided into three streams, those that are **externally** focused on assisting clients (operational social worker), and those that are focused **internally** on the social worker to improve service to the clients. This internal function is further divided into oversight function performed by senior social workers, and quality assurance and adherence to policy in relation to both streams, functions which are performed by the chief social worker.

In addition, just like in any other entity, the performance of a function automatically includes **administrative processes** that must be in place for that function to be well executed. In all three streams, requirements for administration should be observed in terms of social work processes, as well as the responsibilities outlined in the job description of each stream.

#### EXTERNALLY FOCUSED FUNCTIONS

- Screening of clients
- Opening of cases: registration, intake and risk assessment
- Allocation of case to a social worker and categorisation/classification of cases
- Follow-up of cases through home visits or in-office engagements
- Management of case via involvement of and coordination with stakeholders as needed
- Court preparation and other protective services
- Professional report writing

#### INTERNALLY FOCUSED FUNCTIONS

- Supportive supervision
- Verification of reports
- In-service training
- Meetings
- Monitoring and evaluation
- Caseload management

## OVERSIGHT

- Quality assurance
- Office management
- Supportive supervision to social workers at all levels (senior social worker to social worker, chief social worker to senior social worker, control social worker to chief social worker)
- Reporting
- In-service training

## ADMINISTRATIVE FUNCTIONS (CROSS-CUTTING)

- Registration, opening and categorisation of cases
- Allocation of cases
- Caseload planning and management
- Documenting of processes, preparation for home visits, client engagement, meetings, supervision sessions and other administrative functions that are coupled with provision of a service.
- Reporting on performance (monitoring and evaluation)
- Procuring of resources for social workers to perform their functions optimally, such as stationery, office equipment, transport, etc.
- Reporting on overall performance of the directorate
- Analysis of trends
- Planning and resource allocation

## DATA COLLECTION AND USE

Data use for decision-making is a key function of any service delivery process. All the functions stated above will generate data. In addition, the tools and processes used in case management will ensure data quality that will support data demand and use for informed decision-making for efficient and effective service delivery. The responsibility for collection of data in a specific manner is incumbent upon all staff members that serve the general public. Equally it is the responsibility of each and every staff member to understand the data she/he generates and to use it for own professional decision-making, as well as to contribute to decision-making at regional and national levels.

## COMPONENTS OF ENABLING ENVIRONMENT FOR SUCCESSFUL CASE MANAGEMENT

After training and prior to setting up a case management system in your region, the following will need to be addressed:

### PRACTICAL PREPARATION

- Obtain a stock of case management forms and manuals.
- Ensure sufficient stock of files, registration books and other stationery.
- Assess filing space and request additional cabinets, if needed.
- Review your waiting space for optimal client flow.
- Arrange spaces for screening and intake to take place.
- Put up a notice board to improve client information.
- Obtain clocks for each door (see example below).
- Be ready to change your practises to embrace case management!

**EXAMPLE OF A DOOR CLOCK****SYSTEM SET-UP**

- Set up a **screening system** that suits your regional office and constituency offices, ensuring that clients are seen quickly to ascertain the reason for their visit. This is a customer service approach, and improves client flow and waiting times generally, ensuring that anyone waiting in the wrong place is redirected, and that a client who has been seen before is referred to the correct social worker. A screening system also ensures that social workers see only the new cases which require their attention, and that urgent cases are given priority. Administrative officers, social work student interns, or any others designated to carry out this task can be supervised to play this role. Alternatively, social workers can perform screening on a rotational basis. During the screening process Form CM2 Part 1 (demographic profile) may be completed. CM5 (Bi-directional Referral Form) may also be completed in the case of immediate referral. It is important to establish an appropriate place for screening, normally in a reception area, where the screener can have sight of the queue, but also where a confidential conversation can be held. Similarly, seating in the waiting area should be arranged, or a queue numbering system established, so that clients can be screened in the order in which they arrive. In some offices, a reception area may need to be set up.
- Set up an **intake system** for new cases that have been screened and require assessment by a social worker. This should be a system which suits your office (see suggestions below). During intake, the social worker interviews the client, completes initial forms (except CM2 Part 1, which may have been completed during intake) and assesses the level of risk. The person doing intake may also register the case in the registration book, or hand the file to the person with this responsibility. To support effective management of the intake process, more experienced social workers can be assigned on a permanent basis to perform this function; however, an entry grade social worker may be assigned with the assistance of an intake supervisor who will guide this process. Staff may also be assigned on a roster basis in line with the agreed-upon intake days and intake times. The process of intake is explained more fully in the guidance for completing Form CM2.

- Ensure your **case registration book, case file numbering system and case categories** are in line with MGECW protocols; see **Job Aid 11: Registration and Filing**.
- Set up a social work programme structure which suits your region and constituencies. Structuring the social workers' program on a daily, weekly and monthly basis ensures that clients are serviced fairly; clients are made aware of when social workers are available for appointments and when they are not, due to meetings, training, etc. Social workers can thus manage their workload efficiently, and not become overwhelmed. Structuring a programme includes:
  - A. Determining how clients will be serviced. For example, will all days of the week be allocated to seeing clients, or only certain days? What happens in an emergency? Which days are allocated for follow-up and which for meetings, in-service training or supervision? Scheduling can be decided together with all the regional office staff in order to obtain their buy-in.
  - B. Depending on the outcome, design and document how the office will operate, looking at all facets of operations that involve the human element.
  - C. Ensure that relevant information is available to the public by means of a noticeboard in the front office and a clock in front of each door.
- Set up or adapt your existing **supportive supervision framework and timetable** to suit your region and constituencies, and to adhere to the guidelines outlined in the annexed **Case Management Manual**.

#### **STAKEHOLDER COLLABORATION**

Hold a special CCPF meeting or an ad-hoc stakeholder day at regional level to pave the way for integrated case management and strengthened CCPF engagement in your region.

This gathering will serve to encourage stakeholders to learn about one another's services, promote networking, inform stakeholders about the role of integrated case management in the context of the CCPA, and promote involvement in and realignment/strengthening of the CCPF accordingly. Similar stakeholder meetings can also be held at the constituency level as needed. **Suggested objectives can be:**

- To be introduced to the CCPA, its key reporting requirements and the role of case management in its implementation;
- To share experiences on case management and how the different systems intersect;
- To understand the role of the CCPF as a platform for community and stakeholder collaboration;
- To discuss and identify recommendations for more effective integration of services.

**FOR INFORMATION ON THE FOLLOWING TOPICS, REFER TO THE POSTERS DEVELOPED BY THE MINISTRY OF EDUCATION, ARTS AND CULTURE, WITH SUPPORT FROM USAID AND UNICEF.**

- Mental Health – Red Flags
- Deprivation and Neglect
- Sexual Abuse
- Emotional and Behavioural Difficulties
- Physical Abuse and Neglect

A copy of each of the above posters should be displayed in every office.



**ANNEX:**

Supportive supervision manual  
for case management

## Glossary

CONCEPT	DESCRIPTION
<b>Assessment job performance</b>	Constitutes the formal objective appraisal of a worker's total functioning on the job over a specified period of time. It resorts under both the administrative and the educational function; in the latter function it contributes to professional growth. <sup>35</sup>
<b>Communication skills</b>	Communication skills are used in formal communication up and down the hierarchical line of authority, as well as horizontally between supervisor and worker. To be effective, directives and information should pass unimpeded along both these axes, allowing for two-way flow. Communications should be relevant, unambiguous, sufficiently detailed and timely. <sup>36</sup>
<b>Conceptual skills</b>	Conceptual skills are those that enable the supervisor to visualize the organization as a functioning whole, understanding all its constituent parts, its functioning within an environment consisting of other systems, its influence on these, as well as its response to influences from the environment and social, economic and political factors. Consequently, the supervisory thrust will be on integration, coordination and facilitation of both an intra- and inter-organizational level. <sup>37</sup>
<b>Directing</b>	Directing includes influencing, activating, guiding or supervising workers in their work activities. <sup>38</sup>
<b>Effective</b>	Effective refers to the execution of the correct actions and activities; to obtain the correct information and to make the right decisions. The supervisor is effective when the activities and behaviour that she/he reveals contribute to achieving her/his personal goals, as well as the goals of the organisation. <sup>39</sup>
<b>Efficient</b>	Efficient means the correct execution of activities in order to achieve the planned goal through the best methods and procedures and in a cost-effective manner. A service is efficient when it is a manifestation of economic and appropriate usage of resources without sacrificing quality. <sup>40</sup>
<b>Group supervision</b>	Group supervision is a negotiated process in which members come together in an agreed upon format to reflect on their work by sharing their skills, experience and knowledge in order to improve both individual and group capacities. <sup>41</sup>
<b>Human skills</b>	Human skills are those of attending, relating and self-awareness. These imply understanding the actions, beliefs and attitudes of others, and recognizing that they may differ from those held by oneself. <sup>42</sup>
<b>Monitoring</b>	Monitoring is the systematic process of observing, tracking and recording activities or data for the purpose of measuring program implementation and progress towards achieving objectives.
<b>Organizing</b>	Organizing consists of determining what activities need to be carried out to get a job done, assigning these activities to workers, and giving workers the authority to carry out these activities in a co-ordinated manner. <sup>43</sup>
<b>Peer supervision</b>	Peer supervision refers to a process in which one worker seeks supervision from another worker (a peer). <sup>44</sup>
<b>Planning</b>	Planning enables the supervisor to develop and plan the course of action needed to accomplish a service objective. The objective must clearly spell out what must be achieved. <sup>45</sup>
<b>Team supervision</b>	Team supervision, unlike peer or group supervision, involves working with a group that has not come together for the sole purpose of joint supervision, but has an interrelated work life outside the group as well. <sup>46</sup>
<b>Technical skills</b>	Technical skills include the specialized knowledge and skill required in working with procedures, processes and any equipment related to administration.

<sup>35</sup> McKendrick, Brian W. et al. Introduction to Social Work in South Africa; Owen Burgess, 1987.

<sup>36</sup> Ibid.

<sup>37</sup> Ibid.

<sup>38</sup> Ibid.

<sup>39</sup> <https://repository.up.ac.za/bitstream/handle/2263/26952>

<sup>40</sup> Ibid.

<sup>41</sup> Critical Social Thinking: Policy and Practice Volume 2, 2010 - Morrison 2003:200,

<sup>42</sup> McKendrick, Brian W. et al. Introduction to Social Work in South Africa; Owen Burgess, 1987.

<sup>43</sup> Ibid.

<sup>44</sup> Payne and Scott. Critical Social Thinking: Policy and Practice: Volume 2; 2010.

<sup>45</sup> McKendrick, Brian W. et al. Introduction to Social Work in South Africa; Owen Burgess, 1987.

<sup>46</sup> Payne and Scott. Critical Social Thinking: Policy and Practice: Volume 2; 2010.

## Objectives

The objectives of the Supportive Supervision Manual for Case Management are:

- To ensure that supportive supervision as a reflective practice is introduced and supports the introduction of the case management approach to service delivery;
- To provide a framework for the senior, chief and control social workers to provide supportive supervision to social workers in a standardized manner;
- To define the practice, different types of and tools for supportive supervision;
- To align the process of supportive supervision with the case management process;
- To define the roles and responsibilities of each actor involved in the different levels of supervision.

All these objectives are intrinsically linked to the object of supervision broadly which is... ***to provide clients the best possible service in accordance with the Social Work code of professional ethics, practice-based evidence and organizational policies and procedures.***

## Audience

This supportive supervision manual is intended for use by all management staff inclusive of Directors, Deputy Directors, Control Social Workers, Seniors and Chief in the employ of the Ministry of Gender Equality and Child Welfare who hold a supervisory position, and are therefore specifically tasked with providing supportive supervision to social workers at national, regional and constituency levels.

## Introduction

4Children's Project on Case Management recognized the need to develop a case management supportive supervision manual to support and strengthen practices for social workers in the MGECW and to implement the case management system. The development of this manual will provide a framework that will promote uniformity and cohesion in the provision of supportive supervision of social workers in MGECW.

Supervision is well established as an important component of professional social work practice (Kadushin, 2002; Shulman, 2010). It serves as a client protection function in the public and private sectors, and provides a safeguard against inappropriate and poor practices. Competent supervision has been shown to significantly improve decision-making regarding children and families by ensuring that it is in line with good practices in the provision of services in social welfare/work. This is equally important for professional case managers, administrative officers and other paraprofessionals and student interns.

### DEFINITION

#### A. SOCIAL WORK SUPERVISION AND SUPERVISOR

Supervision is a process whereby the supervisor performs educational, supportive and administrative functions in order to promote efficient and professional rendering of services. A supervisor is delegated the authority, and thereby assumes the responsibility, to promote ongoing learning and improve performance of the people that he or she

supervises. The supervisor is responsible for providing direction to those supervised, who in turn are responsible for applying social work theory, knowledge, skills, competency and ethics in the practice setting<sup>47</sup>.

Supportive supervision is therefore an interactional process between the supervisor and the supervisee, and implies the formation of a professional relationship between the two. A social work supervisor is a staff member who has much more experience than the social worker, and *'to whom authority is delegated to direct, coordinate, enhance and evaluate the on-the-job performance of the supervisees for whose work she/he is held accountable. In implementing this responsibility, the supervisor performs administrative, educational and supportive functions in interaction with the supervisee in the context of a positive relationship. The supervisor's ultimate objective is to deliver to agency clients the best possible service, both quantitatively and qualitatively, in accordance with agency policies and procedures'*<sup>48</sup>. The supervisor is thus responsible for providing direction to the supervisee, who is in turn responsible for applying social work theory, knowledge, skills, competency and ethics in the practice setting.

## B. PURPOSE OF SUPERVISION

Supervision has a six-fold purpose in order to provide quality service:

1. Knowledge and skills development
2. Social worker professional development
3. Self-reflection facilitation and support
4. Social justice promotion
5. Administrative task performance
6. Management system performance support

For all social workers, access to supervision promotes a deeper understanding of social work practice and options for intervention. This supports the primary professional obligations of Social Workers while promoting the best interests of clients by ensuring that practice is based on current knowledge<sup>49</sup>.

## C. GUIDING PRINCIPLES

Supervisors in the MGECW form part of the management echelon, and are social workers by profession. Therefore, the core values and principles remain relevant and should form part of the guiding principles of supervision. The internationally acclaimed Social Work Code of Professional Ethics<sup>50</sup> outlines six core social work values and principles, which are integral to these supervision standards.

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<sup>47</sup> Peiser (1988:12-13) describes social work supervision as a process through which the supervisor and the social worker interact with each other in a structured learning situation. The learning situation is structured in such a manner that the social worker can be assisted with the development of his professional skills. It is done through the systematic exploration of existing and new knowledge, skills and attitudes as well as the correct implementation thereof in the rendering of services. The social worker is also developed and enriched with regard to his interpersonal abilities as it comes out within supervision sessions. De Wet (1991:13) concludes that supervision must enable the social worker to render a sufficient and effective service:  
<https://repository.up.ac.za/bitstream/handle/2263/26952/02chapter2>

<sup>48</sup> Kadushin (1992:22-23) defines the supervisor very comprehensively: *'A social work supervisor is an agency administrative staff member to whom authority is delegated to direct, coordinate, enhance and evaluate the on-the-job performance of the supervisees for whose work he is held accountable. In implementing this responsibility, the supervisor performs administrative, educational and supportive functions in interaction with the supervisee in the context of a positive relationship. The supervisor's ultimate objective is to deliver to agency clients the best possible service, both quantitatively and qualitatively, in accordance with agency policies and procedures'*: <https://repository.up.ac.za/bitstream/handle/2263/26952/02cha>

<sup>49</sup> Draft Supervision Standards for Swaziland; unpublished; Human Dynamics Consultancy; August 2017.

<sup>50</sup> <https://www.socialworkers.org/About/Ethics/Code-of-Ethics>

These core values are:

1. Respect for the inherent dignity and worth of persons
2. Pursuit of social justice
3. Service to humanity
4. Integrity in professional practice
5. Confidentiality in professional practice
6. Competence in professional practice

Regarding supportive supervision, competence in professional practice outlined above demands that social workers have a responsibility to maintain professional ability, continually strive to increase professional knowledge and skills, and apply new knowledge in practice commensurate with their level of professional education, skill and competency, seeking consultation and supervision as appropriate<sup>51</sup>. The Social Work and Psychology Act 6 of 2004<sup>52</sup> provides social workers in Namibia with the Ethical Code for Practice.

Supervision is fundamentally a different function than provision of direct social work to clients, and enters into the realm of management practice, which by nature has as an outcome its own guiding principles. The principles of supervision should:

- Focus on achieving better outcomes for service users and carers.
- Promote an evidence-accountable practice.
- Establish clear practice roles and responsibilities.
- Build capacity for development and improvement<sup>53</sup>.

This supportive supervision manual has been developed to assist and advance social workers' understanding of the case management approach adopted by MGECW, and therefore the case management principles outlined in the Case Management Operational Manual of Namibia (pages 6-7) are applicable. In addition to the principles, the legal and policy framework, particularly the Child Care and Protection Act 3 of 2012<sup>54</sup> (CCPA) that informs the mandate of the MGECW, must form the basis for all decision-making during the supervisory process.

## Practice of supportive supervision

Effective supervision is integral to the continual development of social services. Reflecting on practice in supervision provides social workers and case managers with support when dealing with complex, responsible and emotionally challenging work. They are continually expected to make decisions that may affect a child's life positively and/or negatively. Supportive supervision can assist, support and provide oversight to case managers in the management of their caseloads. This can result in case managers who feel more empowered and lead to more effective child protective services. However, the context within which supportive supervision takes place must be a supportive learning environment that actively encourage continual development of good practice and skills. Regular, high-quality, organized supervision is key to developing staff skills, knowledge and values.

<sup>51</sup> <http://www.socialworkers.org/About/Ethics/Code-of-Ethics>

<sup>52</sup> [http://laws.parliament.na/cms\\_documents/social-work-and-psychology-fddc4a9b73.pdf](http://laws.parliament.na/cms_documents/social-work-and-psychology-fddc4a9b73.pdf)

<sup>53</sup> [http://www.stepintoleadership.info/assets/pdf/what\\_is\\_supervision](http://www.stepintoleadership.info/assets/pdf/what_is_supervision)

<sup>54</sup> <http://www.lac.org.na/laws/2015/5744.pdf>

Supportive supervision should take place at any level at which managing of staff for performance is involved. It takes place between different management positions at a national, regional and constituency level. For example, at national level, the director is expected to supervise his or her deputy directors; deputy directors supervise the control social workers; control social workers supervise the chief social workers; chief social workers supervise senior workers; senior social workers supervise entry or operation level staff.

It is good practice that the MGECW define the span of control for each level. At regional levels, the same applies, but additionally the MGECW should identify and define the different management functions that the most senior position in the region must undertake.

The practice of supervision relies on the supervisor to implement this responsibility through the performance of three functions of supervision, namely, educational, supportive and administrative<sup>55</sup>, through interaction with the supervisee in the context of a supportive learning environment. These are:

EDUCATIVE FUNCTION	SUPPORTIVE FUNCTION	ADMINISTRATIVE FUNCTION
<p>In educational supervision the primary goal (Kadushin, 1990) is to increase knowledge, attitude and skills required to perform the job. This task process encourages reflection on, and exploration of, the work. Supervisees are helped to better understand clients, become more aware of their own reactions and responses to clients, understand the dynamics of how they and their clients interact, and examine their interventions and the consequences of their interventions.</p>	<p>In supportive supervision the primary goal is to improve morale and job satisfaction (Kadushin, 1992). Workers are recognized as facing a variety of job-related stresses, which, unless they have help to deal with them, could seriously affect their work and lead to a less than satisfactory service to clients.</p>	<p>In administrative supervision the primary goal is to ensure correct, effective and appropriate implementation of agency policies and procedures. (Kadushin, 1992).</p>

In addition to the functions that the supervisor is expected to perform, supervisors should be in possession of the required skills. These are:

- Technical skills to work with systems procedures and processes related to administration.
- Human skills relating to attending, building relationships, self-awareness and good communication capability.
- Conceptual skills that enable the supervisor to visualize the organization as a functioning whole, i.e., understanding all its constituent parts, its functioning within an environment consisting of other systems, and its influence on these, as well as its response to influences from the environment and social, economic and political origins.

In summary, the educative function is designed to improve self-awareness and increase the social worker’s knowledge base and decision-making abilities. The educative function should also lead to increased knowledge of available resources and ways to make appropriate referrals.

The supportive function of supervision includes elements of emotional support and encouragement, while administrative function should serve to safeguard consistency between philosophies, policies and procedures and actual work performance (Davis, 2010; Shulman, 1993).

<sup>55</sup> University of Pretoria Learning Manual on Supervision: Chapter 2: Social Work Supervision. <https://repository.up.ac.za/bitstream/handle/2263/26952/02chapter2>

## Models of supportive supervision

There are different models generally practiced in supportive supervision. These are:

- **Individual supervision:** a one-on-one model of supervision, and the most commonly used model in supportive supervision. This model is between the supervisor and the supervisee.
- **Peer supervision:** differs from traditional forms of supervision in which a qualified “expert” manages the process and provides supervisory feedback. In contrast, peer supervision refers to a reciprocal arrangement in which peers work together for mutual benefit, emphasizing self-directed learning within the context of support and sharing.
- **Peer-group supervision:** a group of social workers with similar knowledge and skill levels meet regularly to discuss professional challenges, new interventions and solutions, ethical dilemmas or situations, difficult caseloads and caseload management.
- **Group supervision:** a negotiated process whereby members come together in an agreed-upon format to reflect on their work by sharing their skills, experience and knowledge in order to improve both individual and group capacities.

For the purposes of this manual, only individual and peer group supervision are included in the guidance.

Ideally all social workers should have access to a supervisor, a control social worker or an individual in a similar role. (See information on peer supervision below for situation in which this is not available.)

### COACHING AND MENTORING

These are activities and learning approaches that involve employing problem-solving techniques for better client case outcomes (coaching), and help the case manager to feel more competent and motivated (mentoring) to improve performance as a case manager. In the long run, both processes help the case manager feel supported, valued and progressing towards greater achievements.

Supportive supervision is the process of helping staff to build upon strengths and continually improve their own work performance; it encourages open, two-way communication and building approaches that facilitate problem solving, focuses on monitoring performance towards goals, and uses information from cases to make informed decisions. In addition, effective supportive supervision depends upon regular follow-up with social workers to ensure that suggested interventions are being implemented correctly.

There is evidence that a supportive approach in which supervisors and supervisees work together to solve problems and improve performance delivers improved results for child protection services. This approach is much more empowering to both the supervisor and supervisee than the traditional approach to supervision. The traditional approach had as its foundation a controlling approach, characterised by fault finding, limited relationship building, problem solving and follow up, with the result that it was an administrative process, with little focus on empowering the supervisee to improve performance.

## Roles and responsibilities

The function of supportive supervision can be compared to an entry level management position: it aims to improve the performance of individuals, who in turn improve organizational performance. Roles and responsibilities are derived from the management body of knowledge.

## **SUPERVISOR**

### ***A. Planning***

- Plan a course of action needed to accomplish the service delivery objective.
- Adhere to set supervision session dates and times.
- Prepare for all supervision sessions.
- Open a supervision file for all supervisees.
- Record all supervision sessions and keep copies of records in supervisees' files.
- Provide copies of records to supervisees.

### ***B. Organizing***

- Assign cases to workers, and delegate to them the responsibilities and the authority to carry out the required service delivery activities.
- Schedule appropriate return dates for progress feedback regarding plans to be implemented as part of the case management plan.
- Negotiate frequency, time and place for supervision sessions.

### ***C. Directing:***

- Provide leadership, motivation and guidance to workers performing their assigned activities.
- Facilitate processes to access resources to support supervisees' intervention plans.

### ***D. Staff management:***

- Supervision should serve as a monitoring tool to ensure effective and optimal performance of staff in relation to service delivery objectives.
- Supervisor to assess all files submitted for supervision to ascertain quality of the intervention; adherence to legal prescriptions, policies and procedures; and to provide feedback to inform staff development needs and oversight monitoring.
- Supervisor to apply active listening skills and appropriate interpretation skills during the supervision session.
- Supervisor to provide feedback to the supervisee on the outcome of the file assessment.
- Supervisor to provide consistent support to supervisees to ensure enhancement of service delivery and professional growth and job satisfaction of supervisees.

## **SUPERVISEE**

- Adhere to all legislative and procedural prescriptions that guide the service delivery program.
- Guided by the individual caseload management plans, develop and maintain a monthly workload management program.
- Submit files for supervision to the supervisor two days prior to the supervision session date.
- Ensure that the submitted files contain clear records of all interventions made and any planned future interventions.
- Adhere to supervision session dates and times.
- Prepare for all supervision sessions, including submission of agenda items other than discussion points emanating from submitted case files.

- Recognize and identify ongoing development needs and discuss these needs during supervision sessions.
- Take responsibility for own development and actively engage with supervisor to gain support for resolution of issues that impact service delivery and plans for enhancement of growth and job satisfaction.

## Implementation approach for individual supervision

The benefits of effective supportive supervision cannot be overemphasized, and include key outcomes, such as individual motivation, an understanding of the linkage between work and overall objectives, more effective time management, more effective coordination and reduction in stress levels amongst others. However, these outcomes will not be achieved if the implementation approach to supervision is not well thought through. The following is an implementation approach that is based on the three functions of supervision, namely administrative, educative and supportive supervision. Whilst the implementation approaches appear to be focused on the supervisor, the supervisee plays an active participant role in the implementation process.

### IMPLEMENTATION APPROACH FOR ADMINISTRATIVE FUNCTION OF SUPERVISION

- Communicate the organizational expectations, and assist the supervisee to understand the expectation of the job, e.g., service delivery policies and procedures, job requirements (in terms of number of cases to be assigned to the worker, category of cases to be managed, minimum norms and standards, the geographical area to be covered and submission of a monthly workload management plan).
- Agree on the roles and responsibilities of both the supervisor and supervisee, as well as the structure of supervision, e.g., frequency, duration, location and preparation required prior to each session must be discussed. It is advisable that all agreements be included in a supervision contract, which will inform the supervisory relationship and undergo review at agreed-upon intervals.
- Supportive supervision is a professional activity, and as such is a formal process. It is therefore important to record the interaction of formal, informal and/or ad-hoc supervision, including agreed-upon actions and designation of responsible party for the execution of these actions. Both the supervisor and supervisee must keep copies of these records.
- Caseload management is a key feature of administrative function, and therefore a system must ensure oversight by the supervisor of the total caseload of individual social workers. The caseload management function will be discussed in more detail later in the section.

### IMPLEMENTATION OF THE EDUCATIONAL FUNCTION OF SUPERVISION

- Undertake a preliminary assessment of the knowledge, attitude and skills required to effectively execute the job; e.g., for child protection services, confirm supervisee's current level of knowledge, attitude and skills in relation to the assessment, and agree on knowledge and skills that supervisee wishes to develop over the course of supervision sessions.
- Draw up a development agreement with specified outcomes to be evaluated at an agreed-upon time.

### IMPLEMENTATION OF THE SUPPORTIVE FUNCTION OF SUPERVISION

- Together with the supervisee, identify the areas that create stress and discuss self-care strategies.
- Define the elements of the supervisory relationship that may induce conflict or lead to misunderstanding, and propose ways to deflect and decrease these.
- Discuss how both parties will strive for open and effective communication that will assist with the implementation of an ongoing supportive supervision process. Discuss the importance of confidentiality in the supervision process.

While it is important to schedule formal supervision sessions, there is also a need for more informal, and sometimes urgent, ad hoc supervision. Supportive supervision by its nature should create platforms through which supervisees feel confident raising concerns outside scheduled supervision sessions, enabling them to get the support they need. Similarly, day-to-day interactions provide an opportunity for informal supervision, and supervisors should be aware, and thus take advantage, of these opportunities to promote growth of an individual.

## CASELOAD MANAGEMENT

Caseload management falls within the **administrative function** of supervision in social work, and comprises the management of the total work effort of an individual social worker by her/his supervisor. Caseload management sets out the volume of work to be undertaken by a social worker. It involves the monitoring, evaluation, supervision support and accountability of the performance of a social worker by a more experienced social worker.

The process of caseload management forms a critical element in the supervisory process, as it ensures that each unit of work (case/file) is given an equitable portion of the social worker's time. In order to make caseload management an effective function, supervisors should have a system to manage each individual social worker for whom they are responsible. The caseload management system includes:

- Allocation of cases to ensure there is an equitable and fair approach based on experience, capabilities and current workload.
- A register for each social worker's caseload.
- A register that indicates when each file was last seen and next due date for review (normally referred to as a return date system).
- A process of informing each individual social worker of due dates, which will then allow the social worker to provide/present these cases to the supervisor for review. The review system should comprise:
  1. Allocation of return dates to ensure that the supervisor can exercise the supervisory oversight role and implement strategies to promote continuous improvement of services, while providing the supervisee with the means to account for execution of tasks and responsibilities assigned to the supervisee for each individual case.
  2. Lead times for return dates, which will vary depending on the nature of the task or action that needs to be undertaken by the supervisee.
- A schedule of regular, uninterrupted supervision time with social workers to proactively manage work and decrease crises and stress (Hanna, 2009).

This system will allow supervisors to manage their own workloads and help them to prepare for each social worker supervision session and plan appropriately. It will also allow supervisors to respond in a timely manner to requests for support and assistance from social workers.

## ROLE OF THE SUPERVISOR IN CASELOAD MANAGEMENT

- Increase the supervised social workers' knowledge and skills.
- Offer guidance and provide constructive feedback and monitoring.
- Provide direction regarding goals, priorities and next steps in a case.
- Teach time management strategies for equitable distribution of time to cases.
- Provide assistance with strategies to organize and manage caseloads.

- Identify and prevent work overload for individual social workers.
- Provide an avenue for social workers to establish clear and realistic workload expectations.
- Define and distil the types of cases that help in the social worker's professional development.
- Create opportunities to keep a watchful eye out for potential stress levels, e.g., a preponderance of work with high weightings in one category may indicate potential stress levels better than a count of allocated files.
- Assist social workers to formulate professional interventions and achieve intended outcomes.
- Contribute to the supervision process in terms of discussion about organizational, professional and personal objectives<sup>56</sup>.

### **MANAGING WORK/CASELOAD MANAGEMENT<sup>57</sup>**

- The supervisor must at least take into consideration the following elements when assisting the social worker with caseload management.

#### **COMPLEXITY**

This includes the number of other professionals with whom the social worker is involved. It recognizes the social worker's role in drawing together professional networks, for example, in child protection case conferences and plans or when helping a family to make decisions about the care of a child or children.

#### **RISK**

This considers the professional judgment required of the worker, including if decisions should be made based on risk assessment or life-threatening concerns, or is professional anxiety heightened because of inadequate information, lack of support and/or unpopular action/decision is being taken.

#### **TRAVEL**

Does the social worker have to travel long distances without back-up to difficult-to-reach or dangerous areas?

Supervisors can enhance workload management by providing clear direction about goals, priorities and next steps in a case and by imparting time management strategies.

### **GUIDELINES FOR THE SUPERVISOR IN THE MANAGEMENT OF AN INDIVIDUAL SUPPORTIVE SUPERVISION SESSION<sup>58</sup>**

The following are guidelines to make a supportive supervision session more effective.

- Create a checklist outlining exactly what will be assessed and what is required for employees to get a positive assessment. The check list should be made available to the social worker prior to the actual supervision session. This ensures that the supervisee sees that they are being treated fairly and assessed objectively.
- Process recordings of each individual supervision that includes regular feedback on content and process. This means making time and space for the supervisor and employee to regularly communicate about job performance.

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<sup>56</sup> <http://www.dhsspsni.gov.uk/oss-guide-rit-6-2011>

<sup>57</sup> Thogomelo Project. *Induction Manual for Child Protection Social Workers*, 2016 (Department of Social Development Publication – South Africa)

<sup>58</sup> NPI-CONNECT e-news No 39 Issue/ April 2011

- Discuss challenges and suggestions: supportive supervision should be two-way communication. Social workers interact with clients on a day-to-day basis, and have firsthand knowledge of what is and is not working. Often, social workers have ideas about how to address challenges or gaps; other times they will need advice and suggestions for problem solving.
- Check and review the social worker's capability to fulfil his or her tasks. A key part of supportive supervision is identifying and trying to resolve any issues or challenges faced by the social worker in conducting his or her work in relation to resources, such as transport or communication costs. The supervisor could identify potential budget options, or liaise with others at district level to share transport logistics, for example.
- Follow up after training to ensure that the social worker has opportunities to apply these new skills at work and to share with colleagues.

## PEER GROUP SUPERVISION

**Peer group supervision can be used where there are challenges in terms of availability of consistent, comprehensive individual supervision by an experienced and senior social worker.** Peer group supervision can also be used for peer support in addition to, and in between, individual supportive supervision sessions.

Peer group supervision occurs when a group of social workers with similar knowledge and skill levels meet regularly to discuss professional challenges, new interventions and solutions, ethical dilemmas or situations and difficult caseloads and caseload management.

### GUIDELINES FOR IMPLEMENTATION OF PEER GROUP SUPERVISION

#### A. REGULARITY AND ATTENDANCE

Sessions should be regular and long enough to ensure everyone has the opportunity to participate. Appoint a facilitator for the group, either fixed or by rotation, who ensures that the sessions take place and facilitates the sessions.

#### B. STRUCTURE

A clear framework or agenda makes it easier to enforce boundaries and uphold the quality of the supervision. This also allows for use of structured supervision tools such as analysis of both positive and challenging incidents, issues, dilemmas and experiences; structured questioning; and sharing of practice and feedback.

#### C. PROVIDE A SAFE AND SUPPORTIVE ENVIRONMENT

It is important to make sure that the group feels safe to share their experiences. Supervision sessions should be noncompetitive, nonjudgmental and supportive.

#### D. CRITICAL REFLECTION

It is important that all the group members are able to provide positive feedback, issue constructive challenges where necessary, and avoid giving advice. Group members should support each other to draw on their own reflective abilities.

#### E. SELF-DIRECTEDNESS

Peer supervision encourages supervisees to be self-directed learners determine their own needs, and choose appropriate tools for their development. The space and group should be dedicated to one supervisee and his or her needs at a time, without straying into other members' needs.

#### F. NO 'POST-MORTEMS'

After the end of each session, there should be no further discussion of the issue either inside or outside of the group. This is an essential ground rule that establishes clear boundaries, and prevents supervision material from leaking into other places and processes.

## ALIGNMENT BETWEEN SUPPORTIVE SUPERVISION AND CASE MANAGEMENT – A PRACTICAL GUIDELINE

The following section outlines the role of a supervisor in the case management approach as well as gives guidance to a supervisor regarding the most critical questions to be asked at each step of the case management process.

Supportive supervision and case management go hand in hand. The following section identifies the roles a supervisor plays in all stages of the case management process once a case has been reported to a social worker.

### STEP 1 | REPORTING OF A CHILD IN NEED OF PROTECTIVE SERVICES

The social worker should inform the supervisor of the reported case in order for it to be added to the social worker's caseload. Critical aspects for the supervisor to note are:

- A. Is the case appropriate for the MGECW?
- B. If yes, proceed to (c); if no, proceed to (d),
- C. Has the case been formally registered and the appropriate steps followed for the opening of a case file, and are the appropriate forms on file?
- D. If no, has the case been formally referred to the appropriate NGO or another Ministry, and has there been feedback that the case will receive attention by the other service provider.
- E. Across all the above steps, it is also important for the supervisor to ensure that the social work practice is followed by the social worker, and that the response determined by the social worker is the most appropriate response for the case.

### STEP 2 | INTAKE AND RISK ASSESSMENT

This is an opportunity for the social worker to review his or her findings with a supervisor. If supervisor is not available to meet or speak on the phone, it is advisable to review the case with another social worker or support panel. This can be a peer group supervision process as well; see section above for the process followed for peer group supervision.

The supervisor should, together with the supervisee, assess the following:

- A. Has the social worker observed the principles of engagement in social work?
- B. Has the social worker applied the assessment process correctly?
- C. Has follow-up been organized for the social worker to complete the intake process with the family?
- D. In the case where the safety of a child is at risk, has the case been discussed with the supervisor to ensure that option pursued is in the best interest of the child?
- E. If removal is considered, a social worker must involve his or her supervisor or another senior social worker if the supervisor is not available; has this occurred?
- F. Has the level of risk been appropriately assessed and appropriate action taken?
- G. Does the file have the appropriate documentation, including supervisor's notes or group supervision notes?
- H. Is there a checklist developed regarding any other documents with which the client needs assistance?
- I. Make an assessment as to whether the social worker needs additional skills in conducting safety and risk assessments, and has the ability to engage and build the relationship with the client and organize capacity building accordingly

### **STEP 3 | SOCIAL INVESTIGATION, CARE PLAN AND COURT REPORT**

The supervisor should review the social investigation before the care plan is developed, and be available for advice on potential stakeholders who can contribute to the care plan.

- A. Is the social worker using the conceptual and theoretical frameworks to aid her/him in conducting the assessments?
- B. Are the various social work techniques evident in conducting the social investigation? These can be observed from her/his documentation and discussion of the process during the supervision session.
- C. Has the social worker assessed the risk correctly, and does the process indicated in the social investigation properly articulate the reasons for coming to the conclusion that the child is at risk? If there are gaps in the articulation and/or assessment of risk, the supervisor should use her/his social work techniques to probe, reflect and explore processes undertaken by the social worker, in order to advise responsibly and ensure corrective action can be organized if need be.
- D. Together with the social worker, peruse the outcomes of the assessment and what steps will follow and why. These steps may include a care plan based on prevention and early intervention, or a court report that may need more support from the supervisor to ensure that the information gathered is synthesized and appropriately presented in an evidence-based format.
- E. Ensure that the draft care plan and/or court report are discussed, and the requirements for appearance at court are planned for with the family and significant others.
- F. Final reports must be signed by the supervisor to indicate both oversight and agreement regarding the final decision that it is in the best interest of the child.
- G. Ensure that all documentation is on the file.
- H. Across the above steps, assess the social worker's ability to analyze information, interpret and synthesize into evidence, report-writing skills, planning and ability to see the 'big picture' in terms of the client, family prognosis regarding follow-through on the plan and the social worker's own ability to define goals that are achievable and simple.

### **STEPS 4-6 | REFERRAL TO OTHERS SERVICE PROVIDERS; ONGOING IDENTIFICATION OF INTEGRATED CASE MANAGEMENT OPPORTUNITIES THROUGH CASE CONFERENCING; FOLLOW UP AND REVIEW OF CASE TO ASSESS PROGRESS TOWARDS GOALS AND IF OTHER SERVICES REQUIRED; UPDATING CARE PLAN, AS NEEDED.**

- A. Supervisor must ensure that the case is appropriately referred to an alternative service provider should the Ministry be unable to provide additional services.
- B. Should the case be retained by the Ministry, the supervisor must ensure that there is a plan by the social worker for follow-up, or that the social worker receives assistance to develop such a plan. The follow-up can include:
  - Home visits,
  - Face-to-face interviews,
  - Visits to the school,
  - Phone calls,
  - Case conferencing or family group conferencing.

Case reviews must be planned for, and must be part of the supervision process of caseload management for which the supervisor is responsible. The norm for case reviews is three-month time frame; this is to ensure that progress is measured, and revisions made if there is a need to change the interventions as indicated in the care plan.

### **STEP 7 | ONGOING CASE REVIEW VIA CASE TRACKING AND SUPERVISION.**

- A. Supervisor must ensure that cases are reviewed during supervisory sessions, and these cases must be tracked using the case tracking tool.
- B. Case closure, once child considered no longer at risk and support mechanisms are in place

### **STEP 8 | CASE CLOSURE**

- A. The social worker must ensure that each case to be closed is first discussed with the supervisor before this ultimate step is taken.
- B. The supervisor must be satisfied that all possible interventions have been pursued, that the goals as set out in the care plan have been met, or that the reason put forward for closure by the social worker has merit.
- C. Once agreement is reached, the social worker must use the case closure form, which must be co-signed by the supervisor.
- D. Both the supervisor and social worker must ensure that the case is closed on the caseload list, and record a notation in the registration book that the case is closed and include the reason for closure.
- E. If there is a closed file section, then the file must be filed in that section.

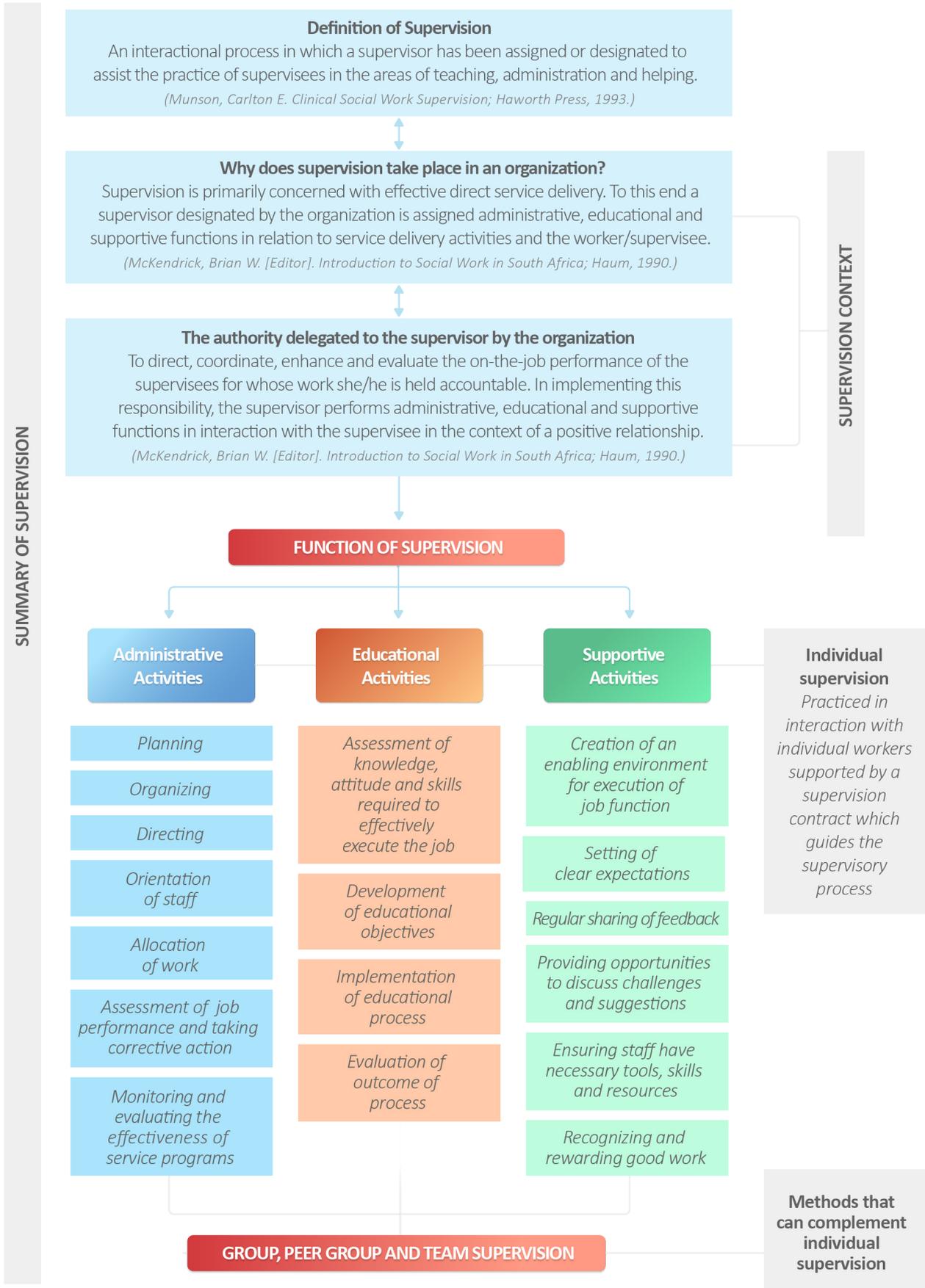
### **CASE TRACKING AND SUPERVISOR LOG**

The case management approach is comprised of definitive steps. As part of this process, the supervisor plays a crucial role of oversight through the use of the case tracking and supervisor log to ensure that the social worker follows each step of the case management process. The checklist is used by the supervisor to ensure case management processes are taking place as required, and to provide supportive supervision in areas where the social worker is experiencing challenges.

### **CONCLUSION**

The importance of supportive supervision cannot be overemphasized in case management. It is a practice that guides and entrenches good social work practice for the benefit of the client. In addition, supportive supervision builds the capacity of social workers, and empowers them with skills that promote personal growth.

## Annexure A | Summary of Supportive Supervision



## Annexure B | Supervisor/Supervisee Social Worker Case Management Contract

Contract entered into between the supervisor (senior/chief social worker and the supervisee (social worker) in implementing the case management process.

Date: DD / MM / YYYY

<b>Regional office</b>	
<b>Social Worker name/title</b>	
<b>Supervisor name/title</b>	

I \_\_\_\_\_ (Supervisor first and last name) \_\_\_\_\_ a Senior / Chief Social Worker

**AGREE to EXERCISE and ABIDE to the following ROLES and RESPONSIBILITIES as a supervisor:**

### 1. PLANNING, CONDUCTING AND RECORDING SUPERVISION SESSIONS

- Plan a course of action needed to accomplish the service delivery objective.
- Negotiate the frequency, time and place of supervision sessions.
- Adhere to set supervision dates and times.
- Prepare for all supervision sessions.
- Open supervision files for all supervisees.
- Record all supervision sessions, and keep copies of all records in supervisee files.
- Provide copies of records to the supervisees.

### 2. ORGANIZING AND MANAGING CASELOADS

- Assign cases to social workers, and give them the responsibility to carry out the required service delivery activities.
- Schedule appropriate return dates for progress feedback on plans to be implemented as part of the case management plan.

### 3. LEADING AND MANAGING FOR QUALITY ASSURANCE

- Provide leadership, motivation and guidance to social workers as they perform assigned activities.
- Facilitate process to access resources to support supervisees' intervention plans.
- Assess all files submitted for supervision to ascertain quality of the intervention and adherence to legal prescriptions and policy procedures to inform staff development needs and oversight monitoring.
- Apply active listening skills and appropriate interpretation skills during supervision sessions.
- Provide feedback to supervisees on the outcomes of file assessments.
- Provide consistent support to supervisees to ensure enhancement of service delivery and professional growth and job satisfaction.



## Annexure B | Supervisor/Supervisee Social Worker Case Management Contract

Contract entered into between the supervisor (senior/chief social worker and the supervisee (social worker) in implementing the case management process.

I \_\_\_\_\_ (MGECW social worker name and title) \_\_\_\_\_ as Social Worker

**AGREE to EXERCISE and ABIDE to the following ROLES and RESPONSIBILITIES as a supervisee:**

1. Adhere to all legislative and procedural prescriptions that guide the service delivery program.
2. Develop and maintain a monthly workload management program guided by individual caseload management plans.
3. Submit files for supervision to the supervisor two days prior to the scheduled supervision date.
4. Ensure that the submitted files contain clear records of all interventions that have occurred and planned future interventions.
5. Adhere to scheduled supervision dates and times.
6. Prepare for all supervision sessions, including the submissions of agenda items other than discussion points emanating from submitted case files.
7. Identify ongoing developmental needs, and discuss these during supervision sessions.
8. Take responsibility for own development, and actively engage with supervisor to gain support for resolution of issues that impact on service delivery and plans for enhancement of growth and job satisfaction.

Signed by \_\_\_\_\_ (MGECW social worker) \_\_\_\_\_ at \_\_\_\_\_ (place) \_\_\_\_\_ on DD / MM / YYYY

Signed by \_\_\_\_\_ (MGECW supervisor) \_\_\_\_\_ at \_\_\_\_\_ (place) \_\_\_\_\_ on DD / MM / YYYY

## Annexure C | Example of a Peer Group Supervision Agreement

<b>THIS AGREEMENT IS BETWEEN</b>	
<b>Supervisee Names</b>	
1. _____	
2. _____	
3. _____	
4. _____	
<b>Organisation</b>	
<b>Start date</b>	<b>Review date</b>
<b>Purpose of supervision</b>	
<b>Peer group supervision arrangements</b> Time, date, location, duration, postponement and nonattendance	
<b>Confidentiality agreement</b>	
<b>Record keeping</b> Who keeps records, where kept, who has access, how to access	
<b>Reporting</b> Who prepares, who receives, how often, content of reports, access for group members	
<b>Agreed expectations of group members</b> Attendance and punctuality, sharing time, honesty and openness, safety, session structure, facilitation role, model of feedback, conflict resolution, what to bring, personal issues, confidentiality, etc.	
<b>Group members' signatures</b>	
1. _____	
2. _____	
3. _____	
4. _____	
<b>Supervisor signature:</b>	
<b>Date:</b>	

## Annexure D | Development Plan

Supervisee name _____				
Supervisor name _____				
COMPETENCY TO BE ADDRESSED	PROPOSED ACTIONS	RESPONSIBILITY	TIME FRAME	EXPECTED OUTCOME
E.g., knowledge and skills on case management	E.g., short course	Supervisee together with supervisor and HR	3rd quarter	Ability to evaluate information from multiple sources, and use information for effective decision-making and continual improvement of service delivery
Supervisee signature		Supervisor signature		
Date signed		Date signed		

## Annexure E | Supervision Process Note

<b>Present</b>		<b>Apologies</b>
<b>Date</b>		
<b>TOPIC</b>	<b>DISCUSSION</b> (NB: Note any specific guidance given by supervisor.)	<b>AGREED ACTION</b>
<b>AGENDA ITEMS FOR NEXT SESSION</b> (If appropriate, e.g., follow-up actions)		<b>PREPARATION REQUIRED</b>
<b>Supervisee(s) signature</b>		<b>Date</b>
<b>Supervisor signature</b>		<b>Date</b>





MGECW Ref #:

Client's surname:	First name(s):	Date of birth: DD / MM / YYYY
<b>Case review and social worker plan of action (Why/Where/When/What/Whom):</b> <i>Five pages for each CM9</i> <b>Supervision review date:</b> DD / MM / YYYY <b>Needs and other actions identified:</b>		
Empty space for case review and plan of action		
<b>Supervision review date:</b> DD / MM / YYYY <b>Needs and other actions identified:</b>		
Empty space for supervision review		
<b>Supervision review date:</b> DD / MM / YYYY <b>Needs and other actions identified:</b>		
Empty space for supervision review		



## Annexure H | Management Roles and Responsibilities as per Job Description of Senior Social Workers and Chief Social Workers Responsible for Region

SUMMARY SUPERVISION STEPS			
Responsibility	Action	Process	Tool
<ul style="list-style-type: none"> <li>Conduct casework when social worker post is vacant or in complex situations.</li> </ul>	<ul style="list-style-type: none"> <li>Manage the caseload in the event that a post is vacant.</li> </ul>	<ul style="list-style-type: none"> <li>Follow case management processes.</li> </ul>	<ul style="list-style-type: none"> <li>Case Management Forms 1-8 as in the Case Management Operations Manual</li> </ul>
<ul style="list-style-type: none"> <li>Mobilize communities to address key issues (e.g., teenage pregnancy)</li> </ul>	<ul style="list-style-type: none"> <li>Determine the trends in order to identify the key issues.</li> </ul>	<ul style="list-style-type: none"> <li>Analyse data on a monthly basis together with other team members (social workers that you are supervising) and with the management team, and determine the key issue(s) to be addressed</li> <li>Discuss with team the most appropriate event that will create awareness</li> <li>Develop project plan and organise event.</li> <li>Execute event.</li> <li>Ensure that a number of events are planned and budgeted for annually in the work plan.</li> </ul>	<ul style="list-style-type: none"> <li>Project plan/Gantt Chart</li> <li>Word Activity Planning Chart</li> </ul>
<ul style="list-style-type: none"> <li>Registration, assign cases, filing</li> </ul>	<ul style="list-style-type: none"> <li>Ensure the existence of registers.</li> </ul>	<ul style="list-style-type: none"> <li>Lead team in creating/implementing routine screening systems to: 1) enhance customer service to ensure clients are where they need to be with minimal wait time, and 2) ensure that AOs are screening all clients for potential social worker services/support.</li> <li>At regular intervals, check that the registers are being completed in the correct manner.</li> <li>Assign new cases (walk-in, telephone and other referrals) to the appropriate social worker by following the process of how cases are assigned. If there is only one social worker in the constituency, then the social worker will be the assigned social worker unless the client reports being from another constituency.</li> <li>Complete the register at intake with the name of the social worker to whom the case has been assigned.</li> <li>Follow up with the social worker to confirm that the new case has been entered into the caseload list, a file has been opened and registered, and that it will be marked for supervision.</li> </ul>	<ul style="list-style-type: none"> <li>Form AO1</li> <li>Register</li> <li>Caseload list</li> </ul>
<ul style="list-style-type: none"> <li>Individual supervision with supervisees on a regular basis</li> </ul>	<ul style="list-style-type: none"> <li>Conduct individual supervision with supervisees on a regular basis for support, guidance and monitoring.</li> </ul>	<ul style="list-style-type: none"> <li>Contract with each worker regarding frequency of sessions, appropriate duration (rule of thumb: new workers meet more frequently; more experienced workers once per month, or when the need arises). Supervision sessions should be scheduled. Supervisors can arrange follow-up sessions for complex/high risk cases.</li> <li>Enter into a contract with supervisee to ensure that each party's roles and responsibilities are understood.</li> <li>Review supervision session agenda, e.g., social worker's ability to manage his or her work, whether the social worker needs additional support, does the supervisee have a number of difficult cases, do they need debriefing, caseload management and return dates and how they are managing this, giving feedback on performance, preparation for in service training, or management meetings. In other words, having an agenda will ensure the session is purposeful.</li> <li>Ensure that each session is recorded.</li> <li>CM9, Part 1: Case tracking should be reviewed and signed off, as should any other forms.</li> <li>CM9, Part 2: Case supervision log. Summary of discussion and next action steps that the social worker must follow should be noted after each review.</li> <li>Explain the return date system to each supervisee so that there is a clear understanding of how caseload management should work.</li> </ul>	<ul style="list-style-type: none"> <li>Diary to track supervision appointments</li> <li>Supervisor/supervisee contract</li> <li>Supervision record</li> <li>Supervision file</li> </ul>

Responsibility	Action	Process	Tool
<ul style="list-style-type: none"> <li>• Caseload management</li> </ul>	<ul style="list-style-type: none"> <li>• Table all cases during supervisory process for follow-up and guidance.</li> </ul>	<ul style="list-style-type: none"> <li>• Ensure that all social workers compile a list of all cases comprising their caseloads (CM9 Case Tracking Form). Each social worker should retain a copy of this list and a copy should be placed in the supervision file kept by the supervisor.</li> <li>• Ensure that this list is kept up to date with the addition of the new cases and deletion of closed or transferred cases.</li> <li>• Compare the register to the caseload lists at regular intervals.</li> <li>• During the first supervisory session, ensure that each case is allocated a return date; this date signifies when the case must routinely be brought for internal quality assurance (IQA) by the supervisor.</li> <li>• Other cases which are more complex/high risk may receive shorter return dates than others that are not as complex. The rule of thumb is that every case in a social worker's caseload should be brought for a IQA process at least once per quarter. The frequency for complex/high-risk cases should be as needed.</li> <li>• Create an index card for each case with the following fields: name, case number, date opened, date seen, return date and supervisor's recommendation. The date seen and the return date must be recorded on the card, as well as on the front of the case cover of the client. Date seen is the return date, which is then deleted at the end of the supervisory session. Index cards should be filed according to months as per return date.</li> <li>• On the outside of the brown folder, write the return date as well, so that the social worker can see when the file needs to be seen by the supervisor.</li> <li>• These cards must be used to manage the caseloads of social workers.</li> </ul>	<ul style="list-style-type: none"> <li>• Supervision schedule</li> <li>• Case-tracking form</li> <li>• Index cards and index box</li> <li>• Supervisory note</li> <li>• Supervisor Case Tracking List</li> <li>• Supervisors Log</li> </ul>
<ul style="list-style-type: none"> <li>• Support social workers:                             <ul style="list-style-type: none"> <li>- Joint interviews</li> <li>- Written report training</li> <li>- Internal quality assurance (AQI)</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Arrange with social workers for joint interview sessions.</li> <li>• Participate in role plays with social workers, especially when managing a complex/high-risk cases.</li> <li>• Support social workers in writing quality reports/letters by assisting them to write a report jointly.</li> <li>• Create a safe and effective learning space by giving social workers opportunities to practice certain tasks.</li> </ul>	<ul style="list-style-type: none"> <li>• Schedule joint interviews with the social worker.</li> <li>• Discuss the case, the purpose of the interview, and the desired outcome.</li> <li>• Role play if necessary.</li> <li>• Create opportunities for social workers to learn new skills or improve their competency, e.g., developing agendas, writing invitation letters or letters informing of event or policy changes.</li> <li>• Schedule learning sessions (can be joint sessions with all supervisees) addressing how to write professional reports. Provide opportunities to provide constructive feedback addressing their own skills and their peers' skills.</li> </ul>	
<ul style="list-style-type: none"> <li>• Statutory: verify social workers' reports before going to court; – canalisation of cases</li> </ul>	<ul style="list-style-type: none"> <li>• If a case has been gauged at medium-to-high risk, the supervisor should be notified, and assist social worker in making decisions on appropriate interventions and writing/developing reports and recommendations.</li> </ul>	<ul style="list-style-type: none"> <li>• Make social workers aware of the role of the supervisor in the risk assessment and subsequent decision-making.</li> <li>• Ensure that when a statutory process is being followed, the social worker brings the report for preliminary guidance at least one week before the court hearing.</li> <li>• All reports destined for magistrate courts, child protection orders and custody and guardianship reports must also be signed by the supervisor to indicate that the supervisor concurs with the recommendations. These reports should be seen by the supervisor for control purposes at least 2 days before the children's court hearing.</li> <li>• Please ensure that copies of reports and all other relevant documents (court orders, children's school certificates, copies of birth registration) are filed appropriately.</li> </ul>	

Responsibility	Action	Process	Tool
<ul style="list-style-type: none"> <li>Reporting to national office</li> </ul>	<ul style="list-style-type: none"> <li>Collation of all supervisee's monthly reports.</li> <li>Collation/assistance with collating regional office monthly reports.</li> <li>Analyses of monthly reports, identification of needs and suggestions to address these needs.</li> </ul>	<ul style="list-style-type: none"> <li>Ensure that social workers complete their daily tally sheets. Encourage them to record any additional information that they feel is valuable on the tally sheets.</li> <li>Monitor tally sheets at regular intervals to confirm that recorded information corresponds with file entries/court appearances, etc.</li> <li>Discuss trends that are highlighted in the tally sheets along with possible responses to these trends with supervisees.</li> <li>Provide feedback to supervisees regarding analyses conducted on their caseload.</li> </ul>	<ul style="list-style-type: none"> <li>Daily report sheets</li> <li>Monthly collation report forms</li> <li>Quarterly report sheets</li> <li>Notes on feedback</li> </ul>
<ul style="list-style-type: none"> <li>Performance agreements</li> </ul>	<ul style="list-style-type: none"> <li>Assist supervisees in the development of performance agreements.</li> <li>Identify training needs or personal development plans (PDPs).</li> <li>Perform staff appraisals.</li> </ul>	<ul style="list-style-type: none"> <li>Consult the Policy for Performance Management in the Public Service.</li> </ul>	
<ul style="list-style-type: none"> <li>Stakeholders management (Child Care Protection Forum - CCPF)</li> </ul>	<ul style="list-style-type: none"> <li>Organise secretariat and manage logistics of the CCPF</li> <li>Guide/monitor stakeholders at the regional level.</li> <li>Attend and report to PTF meetings.</li> </ul>	<ul style="list-style-type: none"> <li>Consult CCPF guidelines.</li> </ul>	
<ul style="list-style-type: none"> <li>Representation of MGECW at every meeting/forum</li> </ul>	<ul style="list-style-type: none"> <li>Ensure that MGECW voice and views are represented in all meetings/forums.</li> </ul>	<ul style="list-style-type: none"> <li>Ascertain/obtain from all other ministries dates of collaborative meetings.</li> <li>Decide which supervisors should attend meetings.</li> <li>Provide written feedback in summary form to other senior team member[s].</li> <li>Discuss pertinent issues and develop responses.</li> <li>Inform the national offices regarding pertinent issues that require a national response.</li> </ul>	
<ul style="list-style-type: none"> <li>Policy development</li> </ul>	<ul style="list-style-type: none"> <li>Form part of a reference group for the development of national policy.</li> </ul>	<ul style="list-style-type: none"> <li>Participate in, and bring grassroots perspectives to, policy formulation</li> <li>Obtain the views of staff on the issues that policies address.</li> <li>Provide feedback regarding the process of development at social workers' monthly meeting.</li> </ul>	
<ul style="list-style-type: none"> <li>Trainings: participation in training of trainers and conducting trainings in their respective levels.</li> </ul>	<ul style="list-style-type: none"> <li>Participate in TOT at national level.</li> </ul>	<ul style="list-style-type: none"> <li>Obtain pertinent training material from the national office.</li> <li>Identify, together with the senior team, how training must be organised.</li> <li>Develop a plan to roll out training.</li> <li>Inform all staff who will be participating.</li> </ul>	







Ministry of Gender Equality  
and Child Welfare